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**NURSES' EXPERIENCES OF PSYCHIATRIC PATIENTS WITH
HIV/AIDS**

A Study conducted in a psychiatric hospital in the Western Cape

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TABLE OF CONTENTS

ABSTRACT.....	iv
CHAPTER ONE: INTRODUCTION.....	1
1.1 Aims of the study.....	1
1.2 Rationale of the study.....	1
1.3 Theoretical orientation.....	2
 CHAPTER TWO: LITERATURE REVIEW.....	 4
2.2 South Africa and the HIV/AIDS epidemic.....	4
2.3 HIV/AIDS and mental health.....	5
2.3.1 HIV/AIDS and related psychiatric disorders.....	5
2.3.2 HIV/AIDS policy and psychiatric hospitalisation.....	6
2.4 Occupational stress in the field of HIV/AIDS care.....	9
2.4.1 Institutional factors contributing to occupational stress.....	10
2.5 Occupational distress in nursing.....	12
2.5.1 The nature of the work.....	12
2.5.2 The role of the health care institution.....	14
2.6 Stressors associated with the care of patients suffering from HIV/AIDS.....	16
2.7 The specific anxieties associated with the nursing of HIV/AIDS patients.....	17
2.7.1 Stigma and willingness to provide care to patients with HIV/AIDS.....	18
2.7.2 Risk and the fear of contagion in HIV/AIDS care.....	20
2.7.3 Nursing of patients with a chronic, terminal illness.....	24
2.7.4 Professional and role issues in HIV/AIDS nursing.....	24
 CHAPTER 3: METHODOLOGY.....	 27
3.1 The research approach and method.....	27
3.2 The research process.....	28
3.2.1 Gaining access.....	29
3.2.2 The participants.....	32
3.2.3 The interviews.....	33
3.2.3 Transcribing.....	36
3.3 Method of analysis.....	37

CHAPTER FOUR: ANALYSIS.....	39
4.1 Nurses' knowledge, previous experience and awareness of HIV/AIDS.....	39
4.2 Difficulties experienced in the care of HIV/AIDS patients.....	41
4.2.1 Fear of contagion.....	41
4.2.2 HIV - the invisible threat.....	46
4.2.3 Caring for mentally ill patients with AIDS.....	49
4.2.4 Violence, psychosis and HIV/AIDS.....	53
4.2.5 Responsibility for the safety of other patients.....	55
4.3 Willingness to nurse HIV/AIDS patients.....	57
4.4 Emotional care of HIV/AIDS patients.....	59
4.5 The ward context.....	63
4.5.1 The busy ward.....	63
4.5.2. The role of the doctor.....	65
4.5.3 The role of management.....	66
4.6 The emotional consequences of psychiatric HIV/AIDS care.....	70
4.6.1 Coping with distress and anxiety.....	71
4.6.2 Response to stress in the workplace.....	73
4.7 HIV/AIDS related anxieties in the personal lives of participants.....	75
4.7.1 The risk of infection outside the workplace.....	76
4.7.2 Responding to HIV/AIDS in the community.....	77
4.7.3 Family and community responses to HIV/AIDS and mental illness.....	78
4.8 Recommendations for improvement.....	80
CHAPTER FIVE: DISCUSSION.....	82
REFERENCES.....	91
APPENDIX.....	96

ABSTRACT

This study aims to explore the experiences of nursing staff who provide treatment and care for psychiatric patients with HIV/AIDS. The study was conducted with a view to understanding the psychological impact of caring for such patients, the additional stressors which may arise as a result of this and how these are dealt with. It was also intended to assist with identifying the needs that staff may have in order to cope with the demands of their work.

Semi-structured interviews were conducted with nine nurses working in the female admission ward of a Western Cape psychiatric hospital. The interview material was analysed to identify common themes which occurred across the interviews concerning participants' experiences, their difficulties and their feelings regarding their work with HIV/AIDS patients. A number of theoretical perspectives were used in analysing and discussing the material, including theories of HIV/AIDS related occupational stress; psychodynamic theory and literature from the field of medical anthropology.

The study found that overall, nursing psychiatric patients with HIV/AIDS was experienced as difficult and stressful by participants, and evoked strong emotions of fear and anxiety. The experience of stress in psychiatric HIV/AIDS care was strongly associated with the nature of the work and the anxieties evoked by nursing patients with a terminal, contagious disease. However, the difficulties experienced by participants also appeared to be related to the context of their working environment, and to extend beyond this to the broader social influences of family and community life. The absence of effective support and acknowledgement of these difficulties has resulted in physical symptoms of burnout and the adoption of individual and collective defences in an attempt to cope with the enormous personal and professional challenges of their work.

CHAPTER ONE: INTRODUCTION

Millions of South Africans are infected with the Human Immuno-deficiency Virus (HIV) and this pandemic will not only severely reduce life expectancy over the next decade, but will also place severe strain on our health care system due to an increased number of terminally ill and dying patients (Saunders, 2000). International studies have found increasing levels of burnout and occupational stress amongst nursing staff caring for this patient population and the experience of stress in this context has been linked to nurses' attitudes and emotional reactions to such patients (Bellani et al., 1996; McCann, 1997; McCann & Sharkey, 1998; Khohi & Horrocks, 1994). Health care staff working with patients with HIV or AIDS (Acquired Immune Deficiency Syndrome) not only have to cope with the stress of physical concerns regarding safe working practices and the fear of infection, but also need to contend with the difficulties inherent in treating ailing, terminally ill patients; the tension associated with caring for this highly stigmatised population; possible identification with patients of their own age and peer group; and repeated exposure to death and dying (Silverman, 1993; Bellani et al, 1996).

1.1. Aims of the study

This study aims to explore the experiences of nursing staff who provide treatment and care for psychiatric patients with HIV/AIDS. The study was conducted with a view to understanding the psychological impact of caring for such patients, the additional stressors which may arise as a result of this and how these are dealt with. It was also intended to assist with identifying the needs that staff may have in order to cope with the demands of their work.

Semi-structured interviews were conducted with nine nurses working in the female admission ward of a Western Cape psychiatric hospital. The interview material was analysed to identify common themes which occurred across the interviews concerning participants' experiences, their difficulties and their feelings regarding their work with HIV/AIDS patients.

1.2. Rationale of the study

By the very nature of their work and their frequent contact with patients, nurses are constantly confronted with the stressors arising from patient care. A review of relevant literature indicates that stress levels in the nursing profession appear to be increasing (Cole, 1992). Mental health nurses are not exempt from this trend, with studies reporting higher rates of absenteeism, lower

self-esteem and personal fulfilment in this group (Fagin, Brown, Bartlett, Leary & Carson, 1995). The South African health care system has undergone massive restructuring in recent years, giving rise to an atmosphere of change and insecurity which has placed new demands on all health care staff. According to the Democratic Nursing Organisation of South Africa, currently more than 300 specialist nurses leave South Africa every month and many of these have given poor working conditions as reasons for their emigration (United Nations Integrated Regional Information Network, 2002).

In addition to these difficulties, health care professionals are now faced with the challenge of caring for a growing number of patients with HIV/AIDS. Although no research appears to have been conducted on the impact of HIV/AIDS care on nurses in psychiatric hospitals, either in South Africa or internationally, the stressors associated with HIV/AIDS care suggest that they are vulnerable to increased levels of stress and emotional exhaustion. Saunders (2000) notes that there are massive mental health implications connected with the rise of HIV infection. While severely mentally ill and intellectually-disabled people are at high risk of contracting HIV, there is now a new psychiatric population who enter the system as a direct result of HIV/AIDS related psychiatric illnesses. The increased strain on the mental health care system as a result of HIV-related illnesses, are likely to impact severely on the work of nursing staff in our psychiatric hospitals.

1.3. Theoretical orientation

A number of theoretical perspectives have been used in this study. Research regarding HIV/AIDS care has focused primarily on the prevalence of burnout and occupational stress amongst health care workers in this field. The term burnout is generally understood to be an extreme manifestation of occupational stress, the end stage of a chronic process, and is described as a syndrome of emotional exhaustion and cynicism which occurs among individuals in the helping profession (Miller, 2000). I have used the literature in this area to highlight the stressors associated with HIV/AIDS care in general hospital settings. Theories of burnout are, however, limited in their understanding of the experience of occupational stress and fail to explore the broader social context in which health care workers find themselves. This study has therefore drawn on psychodynamic theory and the work of Menzies Lyth (1960) to explore the anxieties in nursing work and to provide an understanding of stress and its management as a collective experience. Contemporary authors (Hinshelwood and Skogstad, 2000; Obholzer 1994; Dartington, 1994) have developed Menzies Lyth's ideas to explore anxieties and defences in health care institutions and

their theories are used to explain the emotional impact of psychiatric nursing and the unconscious and collective ways in which these anxieties are managed and distorted. Psychodynamic theory is also used to explore some of the specific anxieties associated with HIV/AIDS care, such as fears of emotional contagion and the anxieties associated with the nursing of dying patients. Literature in the field of medical anthropology (Helman, 2000; Littlewood, 1991) has also been used to understand roles and power relations in nursing and to explore the social construction of the stigma associated with HIV/AIDS.

The structure of the dissertation is as follows: **Chapter Two** is a review of the literature around the central aspects of this study. The emerging importance of HIV/AIDS in the field of mental health is discussed within the South African context and the anxieties and stressors associated with nursing, psychiatric nursing and HIV/AIDS care are explored, from an individual and an institutional perspective. In **Chapter Three** reasons are given for adopting a qualitative research methodology and a detailed account is given of the research process. **Chapter Four** provides an analysis of the interview material, using theoretical concepts discussed in the literature review. Finally, in **Chapter Five** the findings of the study are discussed and concluding comments are made that draw together the central ideas emerging from this research.

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

The following chapter provides a review of literature around the central aspects of this study. It appears that there is no existing literature which explores the combined impact of HIV/AIDS care on nurses working in psychiatric hospitals, and the following review is therefore of literature which explores the experience of stress in the fields of psychiatric nursing, general nursing or HIV/AIDS care. First the prevalence of HIV/AIDS, its emerging importance in the field of mental health care and HIV/AIDS policy considerations will be discussed within the South African context. This is followed by a review of primarily international literature on the issue of occupational stress in HIV/AIDS care. A review of psychodynamic theory around the anxieties in general nursing care and health care institutions will provide a more in-depth exploration of the experience of occupational stress. Finally the stressors associated with HIV/AIDS care and the specific anxieties associated with psychiatric HIV/AIDS nursing care, such as the fear of contagion, will be explored from a number of theoretical perspectives.

2.2. South Africa and the HIV/AIDS epidemic

In 2001 it was estimated that four million South Africans had already been infected with the HI virus and that between five and seven million South Africans would die from AIDS in the next 10 years (Medical Research Council of South Africa). Within the next few years the epidemic will severely reduce life expectancy on the African continent by 20 years (Strachan & Clarke, 2000). The burden on South African society includes the serious impact on the economy, with an estimated 12% of our labour force being HIV positive, and on social progress and stability which is threatened by broken families, social dislocation and an increasing number of orphans (Strachan and Clarke, 2000). HIV/AIDS will also place severe strain on our health care system and health care staff, due to an increased number of chronically ill, dying patients and the increase in opportunistic, infectious diseases such as Tuberculosis. The burden on the individual with HIV/AIDS is extreme, with loss of employment and discrimination from both family and the broader community adding to the physical suffering associated with the disease.

The South African government has not sufficiently addressed concerns about the HIV/AIDS crisis and although this appears to be changing, effective prevention programmes and resources for the

support and treatment of HIV/AIDS patients still need to be implemented (Schneider & Stein, 2001).

2.3. HIV/AIDS and mental health

2.3.1. HIV/AIDS related psychiatric disorders

In South Africa there is a growing awareness of the overwhelming impact that HIV/AIDS will continue to have on our health care system, and yet it is still seen primarily as a physical disease. What needs to be realised, is that HIV infection and the development of full blown AIDS are associated with increased incidents of psychological distress and psychiatric disorder. A South African psychiatrist, Saunders (2000) offers a description of the many psychiatric sequelae of HIV/AIDS. She explains that HIV and AIDS related psychiatric illnesses can occur at any stage after infection and encompass most of the serious psychiatric conditions, from adjustment disorders and psycho-social issues to the more severe forms including depression, dementia and infections of the central nervous system (CNS). Depression occurs in up to 50% of all patients suffering from HIV and can be difficult to diagnose, as loss of weight and loss of appetite, loss of energy and disturbed sleeping patterns are common to depression as well as to other factors related to AIDS. HIV positive patients who are aware of their illness are also 36 times more likely to commit suicide as compared to negative members of the population. As HIV also affects the brain, it appears to produce symptoms, mostly in late-stage AIDS, which are almost identical to those found in patients diagnosed with mania and affective psychosis (Saunders, 2000; McKinnon, Carey & Cournos, 1997). HIV related psychosis differs from schizophreniform psychosis in the experience of prominent visual hallucinations and increased behavioural disturbances i.e. aggression. Furthermore, there are no clinical investigations which can clearly differentiate between functional psychosis in an HIV-positive patient and psychosis which has been caused by HIV infection. HIV related psychosis also appears to herald the onset of HIV associated dementia (HAD), which has a poor prognosis and is accompanied by cognitive impairment and ongoing cognitive decline in up to 80% of patients. Delirium is also common during the early stages of HAD. Anxiety disorders are also common in HIV positive patients, particularly pertaining to the stress of testing and diagnosis.

Saunders (2000) also highlights the vulnerability of severely mentally ill and disabled people to contracting the HI virus. Studies conducted in the USA and Canada to assess patterns of risk behaviour in adults with severe mental illness, have found a low knowledge about HIV and high sexual risk behaviour in this population (Otto-Salaj, Heckman, Stevenson & Kelly, 1998; Chuang

& Atkinson, 1996). Poor impulse control and information-processing abilities, as well as homelessness and abuse, are therefore likely to put this population at risk of contracting HIV. As the mandatory HIV testing of psychiatric patients is not warranted, few statistics are available regarding the prevalence of HIV in this population. Studies conducted in the USA, however, indicate HIV infection rates ranging from 4% - 23% among psychiatric patients who have been tested for HIV (McKinnon et al., 1997).

The pharmacological treatment of HIV/AIDS patients with mental illness is complicated by difficulties in diagnosis and the availability of drugs. Disease-modifying drugs, such as AZT, have been found to be effective in the treatment of HIV related organic brain diseases, which can include symptoms of psychosis (Ostrow & Stryker, 1990), but these drugs are not available in the South African public sector. Medication is therefore used to treat the mental illness, or the symptom, rather than the possible cause. The treatment of mental illness in persons with the HI virus is complex, as HIV infection of the central nervous system results in vulnerability to the side-effects of all medication. Thus, anti-psychotic medication, as well as anti-depressant medication is therefore initially given in low dosages which are then gradually increased. This suggests that patients with HIV-related mental illness will take longer to recover and spend longer in hospital wards (Saunders, 2000).

2.3.2. HIV/AIDS policy and psychiatric hospitalisation

The issue of psychiatric hospitalisation for patients with HIV/AIDS - both those who have a history of psychiatric illness and those who developed a psychiatric disorder because of their infection with the HI virus - is therefore a salient one. This issue needs to be situated against the broader context of psychiatric services in South Africa. The history of mental health care services in South Africa is characterised by the fragmentation and inequality of service and treatment provisions between racialised groupings (Foster & Swartz, 1997). As a result of apartheid legislation, state mental health services for black South Africans were under-resourced and insufficient for the client population. Since 1994 South African state health care services have been undergoing massive restructuring to overcome the fragmentation of services and to change the inherited apartheid administration which was concerned much less with social service delivery than with maintaining a political system of divide and rule. Furthermore, our health authorities are faced with the growing challenge of providing adequate services with limited resources to a patient population with high levels of poverty (van der Walt, 2001). The decentralisation of psychiatric

services and severe budget constraints have also had a serious impact on psychiatric hospitals, particularly academic hospitals and have made it impossible to upgrade psychiatric facilities and increase the number of beds and staff (Robertson et al., 1997). The post-apartheid era has created an atmosphere of change and insecurity which has placed new demands on all health care staff and it is within this context that staff are now confronted with the added responsibility of providing care and treatment for psychiatric patients with HIV/AIDS.

In their suggestions regarding the development of South African government policy on mental health, Lindegger and Crewe (1997) stressed the importance of the establishment of a national mental health policy around HIV and AIDS. They suggested that such a policy should be guided by principles of non-discrimination towards people living with HIV and AIDS, the right of such individuals to quality of life and the right to hospital care which does not subject them to isolation, refusal of treatment, excessive infection control measures and a lack of confidentiality. With regard to psychiatric services, the authors identify the following areas that need to be addressed: Criteria for the admission of patients with HIV/AIDS to psychiatric hospitals, especially in cases where those patients are also suffering from physical illnesses which require medical attention or where they may represent a danger to others, need to be established. The authors also highlight a number of issues which must be addressed within hospitals, including issues of consent and confidentiality around HIV testing, as well as the concern regarding disclosure of a patient's status to their family, the seclusion or restraint of patients with HIV/AIDS and the sexual behaviour of patients with HIV/AIDS. Mention is also made of the importance of the needs of mental health workers in the field and the provision of ongoing education, training, support groups and counselling. Since making these recommendations in 1997, the new Mental Health Care Bill (Parliamentary Monitoring Group, 2001) has been passed, but it does not address the issues of HIV/AIDS. Indeed, there is currently no policy which provides guidelines for the psychiatric hospital care of HIV/AIDS patients.

The lack of policy guidelines around HIV/AIDS and mental health services, however needs to be seen within the broader context of HIV/AIDS policy development and its implementation in the South African health care services. Policy documents regarding the rights of HIV/AIDS patients, the duty of health staff towards these patients as well as recommendations regarding patient support, staff training and effective prevention programmes have been in existence since 1994 when the National AIDS Plan was adopted by the new government. However, these policies,

particularly around patient support and staff training have mostly not been implemented. Schneider and Stein (2001) explore the difficulties that have prevented the effective implementation of AIDS policy in post-apartheid South Africa. These include the difficulty of implementing an ambitious programme through a weak, inherited administration that is undergoing restructuring on every level; a lack of political commitment and the inability of the government to mobilise a broader social response to HIV/AIDS and a lack of enabling leadership which would seek to mobilise and coordinate a range of actors, across a multitude of sectoral and social divides around a common vision.

With the current rates of infection in South Africa, there is an urgent need for our health care system and its workers to respond effectively to the crisis. However, without proper infrastructure, policy guidelines, training and support, health care workers in government hospitals bear the responsibility of responding to the crisis without the means to do so. Mann (1990) explains that the responses of health care workers (HCW) towards the HIV/AIDS epidemic have followed a similar path in countries ranging from Brazil to the USA, and that most HCW remain ill-informed until a national mobilisation on AIDS occurs in their particular setting. Initially HCW know very little about the disease and this is often exacerbated by the rapid pace of new scientific information about the disease and the international media's role of highlighting the problem and providing information to the public. HCW thus face an enormous challenge in processing and applying a barrage of information about HIV/AIDS and the author notes that this has led to the development of particular difficulties in the relationship between HCW and HIV/AIDS patients. These include a reluctance to become involved in AIDS-related work (the stigma associated with AIDS and the high death rate of patients are given as a reason), the perception of clients and society that HCW are not equipped to work with HIV/AIDS patients (this includes the perception that HCW are not able to provide the long-term management and counselling which patients may require) and an antagonistic relationship between HCW and HIV/AIDS patients (primarily caused by the fear of physical contagion). The first phase of HCW response to HIV/AIDS is therefore characterised by a rapid increase of awareness about HIV/AIDS and also a tendency of most HCW to distance themselves from participating fully in the care of HIV/AIDS patients. It also produces groups of dedicated HCW who have responded to the HIV/AIDS crisis and helped maintain the link between HC services and the patients in their care. In many countries the second phase has been characterised by the involvement of community-based and non-governmental organisations. These groups have raised awareness about the illness, promoted the rights and dignity of HIV/AIDS

patients and provided services for counselling and care. Examples of this can be found in European countries, as well as in African countries such as Uganda and Zambia. The third phase of response to HIV/AIDS involves the integration of services and a commitment from HC systems to revise and respond more effectively to the needs of people with HIV/AIDS. The provision of information about HIV/AIDS and the training of HCW is therefore essential for the development of an effective strategy towards HIV/AIDS care and prevention, but HC systems and their leadership are responsible for equipping workers for their roles and providing structures and resources for their work in the field of HIV/AIDS. It would appear from our lack of policy implementation and effective government leadership around HIV/AIDS (Schneider and Stein, 2001), that South Africa is still in the first two response stages to the epidemic. This has serious implications for those currently suffering from the physical and mental illnesses associated with HIV/AIDS, as well as for the health care workers in psychiatric and general hospitals.

2.4. Occupational stress in the field of HIV/AIDS care

In reviewing the literature on the impact of HIV/AIDS care on health care workers (HCW), the terms 'occupational stress' and 'burnout' featured in the majority of articles. In order to understand their application in the field of HIV/AIDS care, these concepts need to be explored further. Miller (2000) differentiates between earlier work stress models which gave insufficient attention to psychological processes and the later 'transactional' model of occupational stress in which an individual's perception of work stressors and their meaning are shown to be the critical mediators of experience of work stress. Thus according to Cox's transactional model (1981, as cited in Miller, 2000, p.14), occupational stress can be seen as "...the psychological state that is or represents an imbalance or mismatch between peoples' perceptions of the demands on them and their ability to cope with those demands". Occupational stress is therefore seen to be an individually-based, affective experience which is associated with subjectively perceived stressors. The term burnout is generally understood to be an extreme manifestation of occupational stress, the end stage of a chronic process, and is described as a syndrome of emotional exhaustion and cynicism which occurs among individuals in the helping profession (Miller, 2000). This notion dominates the literature, providing an account of the measurable impact of HIV/AIDS care on HCW in the field.

Occupational stress and burnout appear to be manifesting in the AIDS field more strongly than in any other medical field (Bellani et al., 1996) and are seen as important factors affecting the quality

of work in this area, having been implicated in reducing quality of care and service delivery (Bennet, Ross & Sunderland, 1996; Kilfedder, Power & Wells, 2001). Commonly reported symptoms of chronic work stress in HIV/AIDS caregivers include physical symptoms such as physical exhaustion and headaches. Behavioural symptoms include increased alcohol abuse, marital and relationship problems, as well as high job turnover and absenteeism (Silverman, 1993). Reported emotional symptoms include emotional numbness and a tendency towards irritability and anger. In assessing the role of individual characteristics and attitudes on occupational stress and job satisfaction in a group of nursing staff, Bellani et al. (1996) found that some feelings and emotional reactions regarding AIDS patients, such as the fear of contagion are significantly associated with chronic work stress. High levels of anxiety and depression were also considered predictive factors of burnout. Silverman (1993) suggests that AIDS caregivers may suffer from a stress syndrome similar to Post Traumatic Stress Disorder. He mentions the exaggerated fears of contagion, emotional numbness and detachment experienced by caregivers of AIDS patients as similar to symptoms experienced by people with PTSD. It is therefore possible that burnout in AIDS/HIV caregivers is related to unacknowledged and untreated psychiatric and psychosocial morbidity and that HIV/AIDS care may have a far more serious impact on caregivers than previously thought. Ultimately, the morbidity resulting from AIDS care needs to be investigated further in order to meet the mental health needs of care providers or “we may find ourselves confronting the unenviable paradox of losing the caregivers in our quest to save the patients” (Silverman, 1993, p. 711).

2.4.1. Institutional factors contributing to occupational stress

In reviewing the research literature on the consequences of occupational stress in the helping professions Bellani et al. (1996) concluded that both situational factors and individual characteristics of health care workers contribute to stress. Staff shortages, increases in the number of patients and lack of resources for adequate care are some of the more obvious situational stressors in HIV/AIDS care, but lack of staff support has also been identified as an important area. In a qualitative research study conducted with hospital staff caring for AIDS patients (Bennet et al., 1996), a strong link was found between reward and end-stage occupational stress, with staff suffering from chronic stress also feeling unrewarded and unrecognised in their work. Staff who had adequate social support from their families and friends and most importantly from the institution in which they worked, displayed a resilience to developing symptoms associated with work stress, and found their work with AIDS patients rewarding. Staff expressed a need for

understanding and support from hospital administration, as well as the freedom to be pro-active about making decisions, rather than adhering to external, organisationally-imposed criteria for achievements and success in caring for their patients. Thus the study determined that where staff were given opportunities to contribute to patient management and were allowed to function autonomously, they were likely to feel that their efforts were appreciated and were thus less likely to suffer from chronic stress. In general nursing care, achievements are measured in terms of patients being nursed 'back to health', but in the field of AIDS care the high death rate and chronic nature of the illness, makes such achievements impossible. Thus, feeling recognised and rewarded in the field of AIDS care is a challenge for staff and there is a danger that the needs of carers will be forgotten or dismissed because the needs of the patients are so great (Bennet et al., 1996).

In exploring the role of organisational support as a buffer to the experience of burnout and occupational stress, Miller (2000), found that support from supervisors was most significant in reducing the effects of work stress. He concluded that having support in the workplace was significantly associated with nurses being able to be empathic towards patients, rather than being detached and cynical about patients' needs. These findings suggest that organisations and institutions have a responsibility towards their staff, to provide them with structures and support to engender a culture of recognition and appreciation for their work.

Theories of occupational stress and burnout dominate the literature that discusses HIV/AIDS care. While this research explores the stressors, both institutional and individual, which interact to create a measurable outcome, it is limited and fails to explore the broader social context in which HCW find themselves. Newton (1995) states that understanding occupational stress requires an exploration of broader issues in the workplace, such as the notions of 'power, emotion and subjectivity' (pp. 2). The author explains that stress can be understood as reflecting power relations between superior and subordinate, for example, and that the manner in which stress is experienced and managed can be a collective process, rather than an individual one. Previously mentioned perspectives on occupational stress also provide a rather limited perspective on the emotional experience and fail to consider how this is influenced by 'codes of emotional restraint' within different organisational settings (Newton, 1995, p. 2). The following is therefore a review of the literature which explores stress and its management as a collective experience, one which is intrinsically linked to the nature of the work. To understand the impact of HIV/AIDS-related

mental health care, the nature of nursing work and the manner in which the anxieties associated with it are managed, on both an individual and on an institutional level, need to be explored.

2.5. Occupational distress in nursing

2.5.1. The nature of the work

When a person enters a hospital for medical treatment, they become a 'patient'. They put their bodies and lives in the care of strangers, namely, the nurses and doctors responsible for their care. While this can be a frightening experience for the patient, the corresponding responses from nursing staff are likely to include flights of idealism, feelings of omnipotence and despondency in the face of such responsibility (Dartington, 1994). The very nature of nursing work can evoke strong anxieties, both conscious and unconscious in nursing staff. The work by Menzies Lyth (1960) in this area suggests that the manner in which they manage these anxieties will effect their own psychological well-being and the way in which they relate to, and care for, their patients.

Menzies Lyth's (1960) ideas were developed in response to her observation of nurses in a general teaching hospital in London in the 1950's. Central to her theory is the psychoanalytic anxiety-defence model which is built on the premise that individuals have conscious and unconscious anxieties and conflicts which are managed by the development of psychological defence mechanisms. Nursing staff, whose primary task is to provide care for patients, have the most direct and sustained contact with patients in a hospital setting and are therefore closest to the anxieties associated with patient care. In nursing patients, nurses are required to perform tasks of a frightening and possibly distasteful nature, and their work can arouse strong conflicting emotions of compassion, envy, fear, pity and anxiety. According to Menzies Lyth, the objective features of nursing are very similar to the phantasy situations of early infancy and may in fact evoke the emotions associated with these early situations.

Infants experience two opposing sets of feelings and impulses, libidinal and aggressive. Feeling omnipotent and attributing dynamic reality to these feelings and impulses, the infant believes that the libidinal impulses are literally life-giving and the aggressive impulses death-dealing... Infants thus fear for the effect of aggressive forces on the people they love and on themselves, grieving for and mourning over others' suffering and experiencing depression and despair about their own inadequate ability to right their wrongs. (Menzies Lyth, 1960. pp. 440-441)

Unconscious phantasies about aggression and the damage done in phantasie by that aggression are thus confirmed when nursing staff are faced with the reality of caring for damaged or severely ill patients. This creates extreme anxiety, which is exacerbated by the need to cope with the psychological stress of patients, their family members and other nursing colleagues. Nurses may

thus be overwhelmed by feelings of burdensome responsibility and the need to repair the damage done.

In the specific area of mental health work, the fears and anxieties of staff are likely to be more complex due to the stigma associated with mental illness and the fragmentation and confusion experienced by patients. The latter may lead nurses to experience anxieties about becoming hopeless and empty like their patients, or of going mad, of losing the capacity to think and make decisions (Sinanoglue, 1987). Contact with psychotic patients is often actively avoided, as the psychotic world may resonate a personal reality which staff have avoided and may lead them to question their ability to prevent their own fragmentation. Building relationship with such patients and empathising with them can thus be perceived as dangerous (Sinanoglou, 1987; Hinshelwood and Skogstad, 2000). With regard to the care of patients with HIV/AIDS and mental illness, additional anxieties are likely to be evoked by negative feelings around the fear of contagion. Individuals also bring personal anxieties and defence mechanisms to their work. In the field of mental health care, some individuals may be drawn to the work because of unconscious reparative wishes or even their own fear of mental pain, which may result in a need to control painful mental states in others and a difficulty in empathising with patients (Hinshelwood & Skogstad, 2000).

In caring for patients nurses are therefore confronted with the painful reality of damage, death, suffering and the emotional distress this evokes in patients and in themselves. If the painful nature of their work can be acknowledged, explored and spoken about, nurses can mobilise appropriate defences to protect themselves and continue with their work. This is similar to findings regarding the importance of supervisor and organisational support to prevent occupational stress (Miller, 2000; Bellani et al., 1996). If, however, there are no opportunities for this and appropriate defences are hampered or blocked, two types of responses are likely. Nursing staff will either display those symptoms associated with occupational burnout, such as absenteeism, psychosomatic symptoms and depression, or will resort to developing pathological defences (Dartington, 1994) against the conscious experiences of anxiety and uncertainty inherent in nursing care. Dartington also highlights the danger of the development of pathological defences in the worker, by indicating that this process can prevent nursing staff from responding fully to their emotional environment. The resulting detachment allows nurses to deny the reality of their situation, a reality which is often unbearable and needs to be challenged in order to preserve both the nurses and the integrity of their task.

2.5.2. The role of the health care institution

Menzies Lyth (1960) broadened the psychoanalytic anxiety-defence model to understand anxiety and conflicts within public health nursing. She found that individual defences can become part of the social system in which people work and can be used, unconsciously, to help defend against the anxieties of their task. These social defences develop through unconscious agreement between staff and become part of the external reality by the removal of the situations, tasks and relationships which cause the anxiety.

Defensive strategies in nursing are centred around limiting personal contact with patients, and to “inhibit the development of a full person-to-person relationship between nurse and patients” as this is at the core of the anxiety (Menzies Lyth, 1960, p. 144). This can be seen in the manner in which tasks in nursing are often split up or staff are rapidly circulated amongst different wards to prevent sustained contact with patients. Other strategies include the depersonalisation of patients where patients may be referred to by their illness, rather than their name, and the tendency to nurse patients in a uniform way, and not according to their particular needs or preferences. Individual distinctiveness is also reduced amongst nursing staff, as differences tend to be restricted to those of rank, with uniforms providing an operational identity which ignores nursing staffs’ personal capacities and needs. Codes of emotional restraint also serve as defences and can be seen in the requirements that staff maintain a professional distance, not become attached to patients and not show their emotions. There is often also strict adherence to rules and procedures in terms of how routine tasks should be carried out and nursing staff are discouraged from using their initiative. Rigid routines and the sterility of the hospital environment serve to protect staff from the risk of both physical and emotional contagion in their work with patients. The defence mechanism of projection is also used to externalise conflicts, such as those arising in relation to responsibility towards patients, by projecting aspects of them into different groups within the hospital system. While this reduces anxiety within individuals it creates conflicts between groups, such as doctors and nurses, and the unconscious reasons for the tension often prevent resolution of the conflict. These defensive systems, while allowing staff to consciously avoid pain, prevent them from processing their emotions and thus experiencing their anxiety less acutely. While nursing staff have little choice about conforming to the required behaviour if they want to fit into the system, the cost of doing so is likely to lead to secondary stress. Thus, the lack of autonomy and inability to use personal judgement, establish relationships with patients and express feelings evoked by the work are likely to result in nursing staff feeling devalued, isolated and resentful. (Menzies, 1988 as cited

in van der Walt & Swartz, 1999). In health care institutions where anxieties are not sufficiently contained and remain unconscious, they are likely to lead to a rigidly defended system where staff adopt a collusive group denial towards the difficulties of their work. The result may well be an environment which would seem shocking to an outsider, but is accepted by HCW within the particular institution.

Menzies Lyth's ideas have been developed by a number of contemporary authors, particularly in understanding the dynamics and defences in mental health institutions. In mental hospitals the anxieties are often evoked by the conflicting tasks of controlling the madness which society finds too difficult to tolerate and providing care and treatment for patients. The fear of being infected by the madness of patients may lead to defensive systems that are centred around keeping the madness in patients and the sanity in staff, and creating rigid barriers to prevent contamination (Hinshelwood and Skogstad, 2000). Not only does this lead to difficulties in terms of restoring patients to a degree of health, it also makes it difficult for staff to own their anxieties and fears and to express these. In her comments regarding institutional defences in a psychiatric ward, Sinanoglou (1987) mentions the manic activity which was used as a defence against anxieties of becoming helpless, and obsessional measures including an emphasis on administrative work which were used by staff as a way of coping with the fear of fragmentation.

Some comments also need to be made regarding the unconscious social role of health care institutions and its impact on staff. While health care institutions have as their stated task the treatment of illness, there is also an unconscious task of containing society's anxieties about death (Stokes, 1994). Psychodynamic theory suggests that we have created health services as a defence against the anxieties associated with death and illness, and as such they should be more accurately labelled as 'keep-death-at-bay' services (Obholzer, 1994, p. 171). In order to act as containers, however, institutions and their staff need to maintain an awareness of the anxiety-containing function of the service and the difficulties of the work. If they are unable to do so, it is likely to lead to an inability to perform both its conscious and unconscious functions. Stokes, (1994) notes that there is a tendency in health care institutions to collude with the death-defying image of hospitals. Thus the dominant medical model is one which aims at curing patients, at preserving life at all cost. If this medical model, in which a cure is idealised, is transferred to the field of psychiatry, it is likely that ordinary care will be denigrated and seen as less effective. For patients with severe mental illness and/or HIV/AIDS, 'cure' is not an option and 'care', and the hope it

brings is what is required. However, if the unconscious aim of the institution, and the staff treating these patients, is that of curing patients, each 'incurable' patient will be a failure and a threat to their professional identity and effectiveness. Thus, the need to see only cures as achievements, could lead staff to feel incompetent and ineffective and may drive them to acts of rejection towards such patients (Stokes, 1994). These comments illustrate the connection between social anxieties and their potential impact on health care institutions when they are not recognised. These social anxieties are likely to be intense with highly-stigmatised illness such as mental illness and HIV/AIDS and will impact on the individual health care workers within psychiatric hospitals, as well as on patients.

The above comments illustrate the role of health care institutions in creating and maintaining social systems as a defence against anxiety. These anxieties are evoked by conflicting emotions around the nature of the work and conflicting aims within institutions, such as control vs care, or care vs cure. Menzies Lyth's theory of defensive systems within institutions, and those of more recent authors, sheds new light on the emotional impact of caring for patients and the unconscious, collective ways in which such anxieties are managed and the distortions which they give rise to. It also allows us to see the impact of the system on the individual nurse and provides a context within which attitudes and behaviour towards patients can be understood.

2.6. Stressors associated with the care of patients suffering from HIV/AIDS

As the psychiatric care of patients with HIV/AIDS is as yet relatively poorly researched, few articles exist which explore the difficulties of caring for psychiatric patients with HIV/AIDS and how this may impact on nursing staff. The stressors and impact of caring for patients with HIV/AIDS has however been researched in the context of general hospital care and the following material is a review of this literature.

Patients with HIV/AIDS require intensive physical and emotional care and the terminal nature of the disease adds to the stress of providing care for individuals who may need support in coming to terms with their diagnosis and its inevitable outcome. A number of studies have assessed the stressors inherent in caring for PWA. These include the fear of contagion and the stress associated with concerns regarding safe working practices; repeated exposure to death and dying; feelings of helplessness and ineffectiveness related to anxiety about providing adequate care for AIDS patients; increased workload and insufficient medical and social resources required to cope with

caring for patients; being subjected to secondary stigma due to the stigma associated with AIDS; possible identification with patients of their own age and peer group and the consequent sense of loss when their condition deteriorates; a sense of futility regarding treatment and anxiety about the responses from family and friends about HIV+ related work (Bellani et al., 1996; Silverman, 1993; Bennet et al., 1996; Miller, 2000).

Although studies have compared stressors in AIDS care to those experienced by nurses in, for example, cancer wards (Catalan et al., 1996), there appears to be a qualitative difference in the stress experienced in caring for AIDS patients, with nurses experiencing the latter as more stressful. The reasons for this may be related to the high profile and contradictory media emphasis that the epidemic has attracted (Miller, 2000), but it is important to note that the AIDS epidemic has raised new, previously unexperienced difficulties for health care workers and the health care systems in which they work. In recent memory there is no other terminal disease which has affected such a large number of young, previously healthy people, leaving health care workers feeling powerless to influence the outcome. Nurses and other health care staff are also confronted with the ethical aspects of AIDS care. In addition to being in the middle of constant societal debates and controversies surrounding the subject of AIDS, the difficulties associated with treating this contagious, fatal illness severely test caregivers' feelings of primary allegiance to their patients, as well as their confidence in their ability to effectively treat the disease (Silverman, 1993). In summary AIDS, more than any other illness in modern times, is confronting health care workers with questions around their personal beliefs, their sense of duty towards those they treat and the quality of life and death of their patients.

2.7. The specific anxieties associated with the nursing care of HIV/AIDS patients

The stressors associated with HIV/AIDS care have been mentioned in section 2.6. above, but the anxieties that these factors may give rise to need to be explored further, particularly within the context of psychiatric nursing. As mentioned previously, current research into HIV/AIDS care does not cover the area of psychiatric nursing care and literature on these two aspects has therefore been collated from different sources. Where applicable, anxieties related to psychiatric care will therefore be discussed alongside those of HIV/AIDS care.

2.7.1. Stigma and willingness to provide care to patients with HIV/AIDS

In exploring the stigma associated with mental illness and HIV/AIDS, the field of medical anthropology offers an interesting perspective on the social dimensions of these illnesses. According to Helman (2000) illnesses such as AIDS which are life-threatening and difficult to treat, explain and control, often come to symbolise more general anxieties in modern society. In popular perception, AIDS has become more than just a clinical condition; in effect it has become a collection of metaphors for what is considered socially or morally wrong with society. These metaphors often centre around the notion of pollution from the outside and include the perception of AIDS as a plague, a destructive invisible force that brings chaos and the breakdown of ordered society, or the notion of AIDS as an invisible contagion, transmitted by any contact with an infected person. Other metaphors include AIDS as moral punishment or as a war waged by stigmatised minorities such as gays and prostitutes. These metaphors are ways of viewing and making sense of the world we live in, but their symbolic associations also have a serious effect on how people suffering from the illness are perceived and treated by others. The use of such metaphors in media and in popular and medical discourses has stigmatised and alienated those suffering from HIV/AIDS and those seen to be at risk of the disease.

Douglas (1966) in her exploration of the rituals of purification used to counteract the experience of dirt and contagion in societies, comments on the universal 'yearning for rigidity' (p. 162), the need in all societies to create order out of disorder. Thus, AIDS and those suffering from it, represent 'a matter out of place' which needs to be controlled through social rituals of exclusion. The stigma and exclusion associated with serious physical and mental illness, can be seen to represent society's fear of harm, of collapse and disintegration and the vulnerability of their bodies (Gilman, 1991; Littlewood, 1991). Once this fear is projected outside onto the 'other', they can locate the fear outside of themselves and are no longer vulnerable to collapse. According to Goffman (1968), the social construction of stigma is intended to separate 'normals' from other, marginalised people and will often manifest in the form of discrimination or exclusion. Thus the stigma associated with both HIV/AIDS and mental illness, and the resulting discrimination against those labelled with the diagnosis, are forms of societal control and create part of the context in which health care workers perform their duties and relate to their patients.

The willingness to provide treatment and care for patients with HIV/AIDS is an important professional requirement for hospital staff and studies examining this concept have found that

attitudes towards patients play a significant role in this regard. In a survey which explored the attitudes of doctors and nursing staff in a general hospital, McCann (1999) found that although staff would not refuse care to patients with HIV/AIDS, some displayed reluctance to deal with these patients and expressed the belief that they should not be compelled to work with patients with this syndrome. There are multiple stigmas and negative metaphors associated with AIDS, which could lead to negative assumptions and beliefs about the character of patients who have a contagious disease which is contracted primarily through sexual intercourse or drug use. Thus, fear of contagion and homosexuality, assumptions about sexual promiscuity, attributing blame and associations with AIDS sufferers being the deviant 'other', are all factors which reinforce negative attitudes towards patients with HIV/AIDS. The implication of stigma for patients with HIV/AIDS is the possibility that nurses and doctors could perceive them as being less deserving of care than other patients and this could lead to discriminatory care (McCann, 1999; Miller, 2000). Thus, although HIV/AIDS patients are seldom refused care, they may not receive treatment equal to that of HIV-negative patients and discrimination could manifest in ways such as being subjected to negative attitudes, being avoided by staff, or having extreme precautions taken by staff when interacting with them.

In another study conducted by McCann (1997) nurses and doctors working in inpatient, general hospital units specifically for HIV/AIDS patients were interviewed to assess their attitudes towards patients and how this affected the willingness to care for them. Those who expressed an enthusiasm and willingness for their work also displayed a strong commitment to providing non-discriminatory care to patients with AIDS/HIV and emphasised the importance of communicating their acceptance and lack of judgement towards these patients. This raises the issue of 'duty of care' (McCann 1997), which is regarded as a moral obligation for all medical staff to provide unconditional care and treatment to patients in an objective, non-discriminatory manner. The nurses and doctors willing to provide care felt that patients with HIV/AIDS should receive nursing care and treatment on the basis of their nursing needs and should not be held responsible for the way in which they contracted the disease. They also reported that they found their work rewarding, both on a professional and on a personal level and mentioned that support from colleagues and family members was an important aspect in their decision to work on HIV/AIDS wards. The different findings in the two studies by McCann suggest that staff are more willing to provide care when they are accepting of patients with HIV/AIDS, feel a strong duty to care and work in HIV/AIDS wards, rather than seeing HIV/AIDS patients in general hospital settings. Working on HIV/AIDS

wards appears to provide staff with support from colleagues, as well as more experience and interaction with such patients. Where longer-term care relationships can be established between patients and staff, the experience helps reduce the fear of HIV/AIDS patients being different or dangerous and therefore further increases positive experiences and a willingness to provide care and treatment (Berkowitz & Nuttall, 1996; McCann, 1997).

Nurses and other health care workers are not exempt from the societal fears around HIV/AIDS and negative attitudes have been linked to both a refusal to care and discriminatory treatment amongst health workers (Miller, 2000). In assessing the attitudes that some health care staff have towards patients with HIV/AIDS, the literature often suggests interventions to improve knowledge of HIV amongst health workers. However, education in the form of improving knowledge about HIV/AIDS does not necessarily lead to the improvement of clinical practice or reduce fears and negative attitudes towards patients. In a study conducted amongst Tanzanian nurses the research revealed that although the nurses had a satisfactory knowledge of AIDS, they were overly cautious and displayed negative attitudes towards the care of patients with HIV/AIDS (Kohi & Horrocks, 1994). Knowledge of the disease is therefore not enough and the role of irrational fears and prejudices must therefore be taken into consideration if the aim is to change peoples' behaviour (Helman, 2000). McCann and Sharkey (1998) suggest that education needs to be more inclusive than merely concerned with biomedical issues of infection control and should ideally focus on attitudes, conditions of work, the level of support available for staff, as well as exploring broader cultural concerns. This suggest that changes in attitude and an increased willingness to work with HIV/AIDS patients will require a holistic approach in terms of education, including the opportunity for nurses to discuss and explore their fears and anxieties around this work.

2.7.2. Risk and the fear of contagion in HIV/AIDS care

In considering the stressors of caring for patients who are suffering from a fatal, infectious disease, the risk associated with nursing AIDS patients and the accompanying fear of contagion must be explored further.

The concept of risk, both in terms of the risk of infection and in terms of risk-taking behaviour in nursing practice is central to the fear of physical contagion. The fear of contagion is most often mentioned as a stressor in HIV/AIDS care and although it may be assumed this would ensure that health care workers take few risks in performing procedures which could expose them to the virus,

the opposite is often the case. In order to protect medical staff from the risk of contracting diseases such as HIV/AIDS, staff are required to comply with infection control guidelines in their work in order to ensure their safety. These guidelines must be followed when handling blood or body fluids or caring for a bleeding patient and involve the wearing of protective gloves, gowns and eyewear, the use of disinfectant and puncture resistant containers for needles (Schillo & Reischl, 1993). In a study examining HIV-related knowledge and precautionary behaviours in a group of Michigan nurses Schillo et al. found that although respondents indicated a high level of knowledge regarding HIV transmission, many failed to consistently use universal precautions against infection. McCann and Sharkey (1998) found the same pattern amongst nurses in Asian countries.

The reasons given in the literature for lack of adherence to safety precautions appears to be twofold. Firstly, work-related environmental factors, such as inadequate facilities or resources and pressures of work may prevent or compromise attempts to adhere to universal infection control guidelines (McCann & Sharkey, 1998). Therefore, if gloves and other protective equipment are awkward, not the right size and not readily available, as noted by respondents in the study by Schillo and Reischl (1993), nursing staff will be reluctant to use them. The second reason given in the literature for failing to use HIV-preventative precautions appears to be that some nursing staff are risk-takers in their work (McCann & Sharkey, 1998). In order to understand this behaviour the literature on the medical anthropology of risk suggests that peoples' perceptions of risk and risk behaviour have their own terms of reference and are likely to differ from the institutional or medical definitions of risk (Kielmann, 2000). Thus, the context in which people find themselves and their perceived level of control over circumstances will inform their behaviour and perception of risk. Douglas (1985) in her work regarding the concept of 'risk' explains that individuals have a strong unwarranted sense of subjective immunity and a tendency to underestimate risk in familiar activities, especially those which they feel should be under their control. The mechanism of subjective immunity is also effective in stressful situations and allows individuals to remain focused on the task at hand, rather than be distracted by concerns regarding the risks they may be taking. If this theory is generalised to HIV/AIDS care it suggests that nursing staff may not take the required precautions in their work with HIV/AIDS patients and if they avoid infection their perception of risk is low, and so the tendency for further risk-taking behaviour is reinforced. Alternatively, adverse working conditions may lead nursing staff to consciously dismiss the risks involved in caring for patients with HIV/AIDS in order to meet the demands of their work.

The emotional component of risk taking behaviour should also be explored and psychoanalytic theory provides a further perspective on the unconscious processes which may result in this behaviour. Risk-taking behaviour can also be understood as the defence mechanism of reaction formation (Freud, as cited in Kaplan & Sadock, 1991), the process whereby unacceptable feelings, in this case the fear of contagion, are controlled by behaviour patterns which are directly opposed to them. Thus, for a nurse the conflicting demands of her duty to care vs her fear of contagion could defend against the resulting anxiety by engaging in risk-taking behaviour. Dartington (1994) in her discussion of pathological defences in the face of unbearable nursing situations, also notes that the defence of manic denial is often used in an attempt to obliterate despair by creating excitement. The manic state of mind would allow nurses to be oblivious to both the physical danger, in terms of risk of infection, and the emotional pain that is likely to be involved in the nursing care of HIV/AIDS patients.

In returning to anthropological theories of risk, risk-taking behaviour must also be seen within the social context of the individual. Douglas (1985, pp. 86-67) goes further to say that individual decisions about whether risks are acceptable are made within the context of the person's environment and it is therefore the culture of an institution which will establish norms about what constitute "appropriate" or "improper" risks. In looking at the concept of risk in the field of HIV/AIDS care, the literature indicates that although institutions provide guidelines for precautionary measures in order to reduce the risk of infection in staff, these measures are often not implemented due to a lack of adequate resources and/or nursing staffs' subjective perceptions of risk, which according to Douglas, are informed by the culture of their environment. This raises questions about how institutions sanction a culture of risk-taking and how this could be changed to protect staff from the risk of infection and the occupational stress associated with it.

If risk-taking behaviour and failure to adhere to universal precautions in HIV/AIDS nursing are in part a defence against the fear of contagion, how do we understand this fear, what are the factors that contribute to it and how does it impact on nursing staff? The fear of contagion is most often mentioned as a stressor in HIV/AIDS care, and Silverman (1993) lists an exaggerated fear of contagion as one of the symptoms of a possible HIV caregiver's stress syndrome. It is present even with those willing to work with HIV/AIDS patients, and has also been associated with avoidance of patients and the belief in the right to refuse care (Bellani et al., 1996). The literature

in AIDS care research identifies a lack of knowledge about HIV transmission as a factor which is likely to contribute to the fear of contagion (McCann & Sharky, 1998), but it is also experienced by nurses who have been found to have adequate knowledge about HIV/AIDS. Explanations for the ongoing fear of contagion include a lack of confidence in the effectiveness of prescribed precautions, the tendency of health care institutions to down play the real risk and a lack of communication between health care authorities and health care workers (Gerbert, 1988 as cited in Bellani et al., 1996).

To understand the fear of contagion amongst HIV/AIDS health care workers the real dangers, as well as the possible phantasies evoked in caring for patients with an infectious, terminal disease must be explored further. Psychodynamic theory with its interpretation of unconscious processes, is a useful theoretical model in looking at the possible underlying reasons for the fear of contagion. The theory suggests that nursing staff working with AIDS/HIV patients are confronted with the physical pain and emotional suffering associated with the disease, such as patients' feelings of helplessness, anxiety and despair and fear of death. These feelings tend to be communicated indirectly in a process known as projective identification, a psychoanalytic term which explains a process whereby unmanageable feelings are projected into another person in order to be managed on their behalf (Moylan, 1994). Anxieties around the real risk of being infected with the HI virus through contact with bodily fluids of the patient are thus likely to be exacerbated by unconscious fears of being infected with the unwanted, negative feelings of patients, as well as by carers' own primitive fears of being damaged or even annihilated through contact with terminally ill patients. The fears of annihilation and disintegration have also been mentioned with regard to the stigma associated with HIV/AIDS and mental illness, and suggest that fears of contagion are linked to a fear of being contaminated by the stigmatised 'other'. These fears of contagion are also in strong contrast to possible reparative wishes that nurses may have, possibly evoking conflicting anxieties about the expectation, or need to care, versus the fear of contagion. If these feelings are not consciously explored and identified, nursing staff are likely to rely on projective identification themselves in order to rid themselves of feelings which are too painful (Moylan, 1994).

Miller (2000) also mentions the fear of social contagion. This form of contagion is closely linked to the stigma surrounding HIV/AIDS and refers to the perception that nursing staff are negatively altered through their association with HIV/AIDS patients. Thus both nurses and doctors have displayed reluctance to work with HIV/AIDS patients because of disapproval from their families

and spouses, and some HCW involved in HIV/AIDS care have reported that they do not inform their families for fear of reprisal.

The fear of contagion in HIV/AIDS care can therefore be understood as a fear of physical, emotional and social 'contamination', which carers defend against by avoiding contact with patients or engaging in risk-taking behaviour which serves to reassert a sense of control into their work. These defences appear to be sanctioned and indeed maintained by occupational, social and institutional factors.

2.7.3. Nursing of patients with a chronic, terminal illness

In caring for patients with HIV/AIDS, nursing staff are confronted with a range of issues associated with the care of terminally ill and dying patients. Involvement with the distressed family and friends of HIV/AIDS patients and bereavement overload, as a result of patient deaths, have been noted as a major source of stress in HIV/AIDS-related nursing care (Miller, 2000). The AIDS epidemic has been unlike other illnesses in term of the number of young, previously healthy people who have been infected and have died from the disease. Working with dying people puts carers in touch with personal loss and evokes unresolved feelings and anxieties about death. Speck (1994) notes that it is inevitable that carers will identify with patients and be constantly reminded of the reality of death and their inability to prevent it, in others or themselves. In an attempt to defend against the anxieties associated with death, nurses may avoid patients or resort to task-centredness and aggressive treatment approaches (Speck 1994).

Identifying with HIV/AIDS patients has been found to be a stressor reported by most health care workers. It has, however, been found to be more stressful in cases where nurses also identified themselves as being at risk of possible HIV infection (Miller, 2000). This suggests that workers who consider themselves at risk, are constantly reminded of their own possible death and their own vulnerability, through their work with severely ill HIV/AIDS patients.

2.7.4. Professional and role issues in HIV/AIDS nursing

The futility of treatment, uncertainty about disease progression, clinical neurological difficulties in HIV/AIDS patients, coping with patients' emotional traumas and providing psychological support, have all been identified as areas which HCW find the most difficult in HIV/AIDS care (Miller, 2000; Bennet et al., 1996). Besides the physical care of patients, the psychosocial impact of

HIV/AIDS requires an emotional component of care, a recognition of the emotional impact of the disease and the life changing consequences for patients and their families. Miller (2000) mentions further demand on staff, such as the need to accept sexuality as a professional focus, an aspect which can be very difficult for staff. Ultimately, the nursing response to HIV/AIDS has expanded the professional role of nursing (Mann, 1990; Miller 2000), thus placing nurses in situations where they have more responsibility, and may be required to adopt a number of roles in their care of HIV/AIDS patients. This may account for the growing concern regarding professional inadequacy in nursing staff and the request for further training in the area of HIV/AIDS (Miller, 2000).

Despite the increase in responsibility for nurses, and the high expectations placed on them in the field of HIV/AIDS care, their lower place in the medical professional hierarchy may place them in situations where they feel trapped, and where they have insufficient authority to make decisions for and care for their patients in the way they would wish (Bennet et al., 1996; Miller 2000). The role of nursing in general, and the position of the nurses within the hospital hierarchy should therefore also be explored. Gender divisions and power relationships in the provision of health care are still similar to those established in the nineteenth century when women first began working in hospitals in a domestic capacity. Since then nursing has become a profession in its own right, but within the hospital structure the doctor is still equated with the 'father' figure, while the nurse is the caring 'mother' and the patient is relegated to the position of 'child' (Littlewood, 1991; Helman, 2000). Nurses have the most contact with patients and this is similar to the mother's contact with the infant as it involves intimate contact with the patient's body and its waste products. Doctors, on the other hand have less contact with patients but their authority rests on their specialised and exact knowledge of the inner workings of patients' bodies. Nurses therefore rank below the doctors in the hierarchy and are subject to their decisions about treatment (Helman, 2000). Power relations in accordance with knowledge are also replicated in the nursing hierarchy, with divisions between junior and senior, registered, enrolled and assistant nurses (Marks, 1994). In terms of power relations the nurse is therefore in a more powerful position than the patient (who is often in a silenced position of uncertainty and pain), but in a less powerful position than the medical doctor. Through sustained contact with patients the nurse is also able to understand illness and its impact in a more holistic manner, rather than being limited by the biomedical view taken by doctors. Particularly with marginalised people such as the chronically sick, nurses can have an important impact on the quality of life of patients and gain an understanding of the meaning patients give to their life and their illness. As such, the role of the nurse can be seen as that of mediator between

the needs of the doctor and the needs of the patient (Samuelson, 1991; Littlewood, 1991). The nurse's role as mediator seems particularly important in the field of HIV/AIDS, a disease which is chronic, fatal and highly stigmatised, yet in their actions nurses are still limited by their duties of carrying out doctors' orders and maintaining hospital routines.

In summarising the anxieties associated with HIV/AIDS, and their impact on nursing staff, the following comments can be made. To quote Mann (1990, p. 233) "one of the most remarkable features of the pandemic of HIV infection and AIDS is a relentless capacity to focus attention on long-standing, complex and unresolved social issues". Society's fear of death and illness and the resulting stigma and fear of contagion associated with HIV/AIDS are all issues which will impact on health care workers who provide care for HIV/AIDS patients. Nurses, who have the most intimate contact with patients not only act as containers for the pollution associated with disease (Samuelson, 1991), but are also in a position to communicate the needs of patients and as such are placed in a position of enormous and overwhelming responsibility. The specific anxieties related to the nature of HIV/AIDS nursing are also compounded by institutional factors such as staff shortages, lack of resources, and lack of staff support. Thus, nurses are expected to cope with an enormous range of difficult aspects of care within challenging working environments.

CHAPTER 3: METHODOLOGY

This chapter will provide an explanation for conducting a qualitative research study and define the research methods utilised. The research process, its participants and the analysis of the research material will then be described.

3.1 The research approach and method

This study focuses on exploring the experiences of nursing staff in the care of psychiatric patients with HIV/AIDS, with a view to understanding the nature of the work and its psychological impact. The emphasis of the study is thus on the personal experiences of a small group of participants within a particular context and an interpretative qualitative research approach was adopted to enable an in-depth exploration of the subjective experiences of participants and the meaning that they attach to their experiences (Banister, Burman, Parker, Taylor & Tindall, 1994). In contrast to quantitative research, which often involves reduction and abstraction, qualitative research approaches focus on understanding a given social setting, as well as the relationships within that system without necessarily making predictions or conclusions about a fixed truth (Janesick, 1994). Qualitative research approaches can be seen as holistic in their attempt to understand the whole by exploring and illuminating the experienced reality of participants, and as such adding to the debate about a phenomenon (Banister et al., 1994; Janesick, 1994). No research has been conducted about the experiences of nurses in psychiatric HIV/AIDS care and qualitative research is also particularly useful in unresearched areas, as uncertainties and gaps in knowledge are actively engaged within the research process and are not considered as limitations (Banister et al., 1994).

Interviews with a semi-structured format were chosen as the most appropriate research instrument for generating data which could give an authentic insight into participants' experiences.

Interviewers in the interactionist tradition, regard the interview process as an interaction between researcher and participant and emphasise the importance of this interactive component in achieving intersubjective depth and an understanding of the participants and their reality (Miller & Glassner, 1997). The interview can thus be seen as a cooperative experience, with both interviewer and interviewee working together to achieve the shared goal of understanding. In qualitative interviewing the researcher no longer adopts the position of a rational, detached and value-free observer, but recognises herself as a central part of the research process. Thus the researcher's class, race, sex and her assumptions and beliefs about the research will not only guide the research

process, but will also affect the participants and what they choose to communicate (Edwards, 1993). While this suggests that the research process is subject to the subjectivity of the researcher and the respondents, qualitative research does not make claims to be objective. Banister et al. (1994) suggest that subjectivity can be seen as a resource and a close approximation of an objective account of a particular phenomenon can be achieved through an exploration of the impact of subjectivity on the research design and process. Reflexivity, or the recognition of the influence of both researcher and participant on the research material, is therefore an important aspect of qualitative interviewing.

The use of a semi-structured interview format was chosen for a number of reasons. My interest was in the experiences of participants with HIV/AIDS patients, as well as how these experiences impacted on staff. I therefore needed to guide the interviews with specific questions, while also allowing participants the space to speak about related issues which I had not considered. The semi-structured interview is an open and flexible research tool which allows for the exploration of complex issues and gives participants the opportunity to express themselves freely, rather than limiting responses to a standard format (Banister et al., 1994). Participants can therefore introduce new material and perspectives which may not have been anticipated by the researcher, leading to richer research material, as well as possibly providing disadvantaged groups with the opportunity of having their views validated and even published. Thus interviews can be tailored to the particular participant and the position she communicates, with the interview schedule providing a loose framework for the researcher (Breakwell, 1995; Banister et al., 1994).

3.2. The research process

My interest in the experiences of nurses with HIV/AIDS patients originated at a time when I was attending ward rounds at the burn unit of a local children's hospital. I noticed that a particular toddler seemed to get less physical attention and affection from the nursing staff, who seemed almost reluctant to touch her. I found myself drawn to this particular child and spent time with her during my next visit. She seemed particularly fascinated by the texture of my skin and instead of grabbing my hand like other children, she gently stroked it. I learned later that she was HIV positive and that nursing staff generally wore gloves when interacting with her. In witnessing the terrible emotional and physical suffering of burn victims on the ward, I had developed an enormous respect for the nurses who worked with these patients on a daily basis. The incident with the child

left me wondering how nurses were able to cope with the added stress of an HIV diagnosis in one of their patients and how this affected them.

Thus the initial ideas for this research were developed and I chose to conduct my study at Bergveld hospital, (the name of the hospital has been changed for reasons of confidentiality) the psychiatric hospital where I had completed my clinical internship one year prior to the interviews. My previous experience of the hospital environment is relevant in the sense that a qualitative research approach demands an awareness of the reflexivity of the research process and researcher's awareness of her own assumption and participation within the research (Bannister, et al., 1994; Edwards, 1993). I had worked in the admissions ward and its two referral wards at Bergveld for three months and was familiar with the hospital system, the ward and some of the staff. Bannister et al. (1994) mention that in research in the discipline of psychology the investigator and investigated coincide. This is certainly the case in this study which was conducted in a ward where I had worked together with some of the participants. My familiarity with the ward meant that I brought my own subjective understanding of the ward, its dynamics and its difficulties, into the research process. In part, my previous experience of the ward as a stressful working environment and my assumption that cases of HIV/AIDS amongst the patients would increase the experience of stress and anxiety amongst nursing staff, guided my interview questions. I was also aware of possible areas of difficulty with regard to the research and in many ways my knowledge of the hospital system informed how I gained access to the participants and how I engaged with them.

3.2.1. Gaining Access

I initially spoke with a number of psychologists and doctors at Bergveld about HIV/AIDS patients in the hospital and issues around HIV/AIDS and mental illness. It seemed clear that some staff were concerned about the prevalence of HIV/AIDS in the patient population, but that these concerns were not being addressed in any systematic way. HIV/AIDS seemed to be yet another problem, one that the hospital did not seem to want to own, or perhaps felt helpless to address. When asked about policy guidelines around hospitalisation of HIV/AIDS patients, a number of doctors said that the Provincial Administration of the Western Cape General Hospital Policy was followed, but no copy of this was available in the hospital or in any of the wards. A general sense of denial seemed to shroud the issue of HIV/AIDS and I realised that there was some sensitivity around my research topic. Furthermore, nursing staff have come under a lot of criticism about the treatment of patients and research at the hospital has often focused on patients' experiences and the

abuse of patients' rights. These issues alerted me to a sensitivity around the topic, both in terms of the possible criticism of the hospitals' lack of guidelines regarding the treatment of HIV/AIDS patients and a concern that I might fault nurses' treatment of such patients. Renzetti and Lee (1993) suggest that sensitive topics of research are those which are seen as potentially threatening to those being studied. Thus, participants may fear that participation in the research process could lead to discoveries of wrongdoing or negligence, and this can impact on every stage of the research process. Any research conducted around HIV/AIDS could be considered sensitive, but ultimately, the sensitivity of a research topic is determined by the relationship between the topic and the social context within which the research is conducted (Renzetti & Lee, 1993). In this particular study the previous criticisms of nursing staff, as well as a lack of policy guidelines regarding HIV/AIDS patients, suggested that the research process could be perceived as threatening and I was concerned that my access to participants would be hampered by this.

As the research was taking place in a hospital ward, I was required to hand a proposal of my study to hospital management in order to gain access to participants. Concerns about the study resulted in the proposal being sent to the hospital ethics committee for further scrutiny. Once the proposal had been passed, I contacted both the psychiatrists on the ward in order to inform them of the plans for the study. Both psychiatrists gave permission for me to conduct the research and one in particular expressed her concern about the impact of HIV/AIDS care on nursing staff. She explained that the current rate of HIV/AIDS infection was 25% of all new admissions to ward 14. In accessing participants I had to start at the top of the medical hierarchy and I was concerned that rumours of my research would reach participants before I had spoken to them myself. The literature emphasises the importance of the route taken to contact participants, as this can impact on the way the researcher and the study are seen by participants (Rubin & Rubin, 1995; Fontana & Frey, 1994). I was also aware of the importance of following the correct route according to procedure and seniority in order not to jeopardise the study. Immediately after speaking to both psychiatrists I therefore contacted the nursing administration of the hospital and met with the matron in charge of the ward. Access through the consultants on the ward may have made it difficult to dispel the image of being associated with evaluation (Banister et al., 1994) and this meeting was therefore crucial to my access to participants, as I believed that support from the nursing department would allay staff fears about the study. In the meeting we discussed the proposal and the questions I would ask. I emphasised that the study was not an evaluation of the nurses' work, but rather an attempt to understand how the work affected them. Once assured that

the study would allow nurses to give their own views on the situation and provide them with an opportunity to talk about their experiences, the matron was extremely helpful and said she would encourage the ward sisters to allow staff to participate in the study during working hours. Officially, I could now access the participants.

I arrived at the ward two days later and went to the nurses' station where I introduced myself to the sister in charge. The nurses, curious as to my reason for being there, stood around and listened while I explained that I was interested in their experiences of nursing patients with mental illness and HIV/AIDS and how the work impacted on them. I explained that I was interested in interviewing any of the nursing staff who would like to participate, and that participation was voluntary. While asking for volunteers raises concerns about volunteer characteristics (Banister et al., 1994), I felt this was outweighed by the importance of establishing trust with the nursing staff and that nothing would be gained in forcing their participation. My request was met with some suspicion and anxiety by the nurses and after answering some initial questions around who the research was for, and why I was interested, I left a copy of the interview schedule with the staff and encouraged them to discuss it. For the next week I visited the ward on a daily basis. I would arrive after lunch, introduce myself to any nurses I hadn't met and explain my reasons for being there. In effect I was negotiating my access to participants and establishing rapport and a level of trust. Staff soon began to chat to me and ask questions about the study and informal group discussions about HIV/AIDS started occurring during my time in the nurses' station. By the end of the week nurses were asking when 'we' were going to start with the interviews, which suggested that nurses actively wanted to engage in the interviews and even felt a sense of it being 'their' process. Rubin & Rubin (1995, p. 93) use the term 'conversational partner' to describe the active participative role of the interviewee in qualitative interviews. This role allows participants to talk about their experiences and to be heard, an opportunity which they may not have had before. In spending time with nurses on the ward, I realised that issues around HIV/AIDS were not often discussed and after their initial anxiety there appeared to be a real need to discuss their concerns and talk about their experiences. As a last step before the interviews, I attended a morning ward round at ward 14 and introduced myself to the interns, medical students and the rest of the team working on the ward.

Gaining access to the participants requires the researcher to have some understanding of their context or 'culture', and to present herself in a non-threatening way in order to gain their trust

(Fontana & Frey, 1994). I already had some experience of the ward context from my previous work as a staff member on the ward and while this facilitated the process of access and establishing rapport, I also needed to communicate the change in my role. I was thus careful to distance myself from my previous role as staff member and to present myself as a researcher who was interested in their experiences, concerns and recommendations around HIV/AIDS patients. Nevertheless, I was aware of being associated with doctors and psychologists in the medical hierarchy. The cautious process of negotiating access seemed to allay nurses' fears about the possibly threatening nature of the research and created a willingness to participate in a process which they could regard as being of benefit to themselves.

3.2.2. The participants

I had initially planned to interview ten nurses from the admissions ward, however, but due to time constraints and difficulties in securing the last interview, nine nurses eventually participated in the study. Participants were all women between the ages of 35 and 55 and their nursing experience ranged from nine years' to 30 years' experience in their field. Issues around race and professional seniority must be taken into consideration in a working environment where perceptions of power and control affect the anxieties of the work. The participants' qualifications and their cultural or racial identity were therefore important to the study. The participants fell into two categories with regard to race and qualification. Four of the nurses were nursing sisters who had received formal training at a university or nursing college. The nursing sisters were all black and Xhosa speaking. The other five participants were either nursing assistants (less than ten years' nursing experience) or senior nurses (more than ten years' nursing experience) who had received their nursing training at Bergveld hospital. These five participants were all so called 'coloured' and Afrikaans speaking. To ensure anonymity, participants were given an interview number, thus the first participant was referred to as nurse 1 and the last as nurse 9.

The length of time that participants had spent on the ward also varied. Ward rotations usually occur every three months but this policy is not strictly adhered to. One participant had only been on the ward for two weeks, while two others had been working in ward 14 for a year. The average length of time was five months. At the time of the interviews, eight of the participants were on day duty (7:00 am - 7:00 pm) and one participant, a nursing sister was on night duty (7:00 pm - 7:00 am). As family support and acceptance of HIV/AIDS care can impact on health care workers

(Miller, 2000) participants were asked whom they lived with and if they had a partner and children. All participants had children or grandchildren at home, and more than half were single parents.

In my initial proposal I had indicated that the interviews would be followed by a group session with all participants, where I could share my understanding of their experiences and allow for feedback and further comment. During the month of the interviews, however, two of the participants left the country and another two requested transfers and moved to other wards. This together with conflicting shift times unfortunately made it impossible to have a group session. The number of nurses leaving the ward also reflects on the conditions in the ward and the effect that this has on nursing staff.

3.2.3. The interviews

Selecting participants was an informal process which relied on the availability of staff on a daily basis. I made one appointment at a time and would then phone the ward in the morning to confirm that the participant was at work and that she would be available to meet with me during the wards' quiet time when patients are asleep. On a number of occasions participants were absent from work on the day of the interview, or were unable to make time on the scheduled day because the ward was too busy with new admissions and other staff were absent from work. Many of the interviews were rescheduled two or three times for these reasons and it also gave me insight into the pressure that staff were under. It is also possible that staff were anxious to talk about their often highly emotive experiences with patients (Edwards, 1993) and cancelled appointments because of this. I was also aware that nurses were giving up their lunch hour for the interviews, a time which is very precious during a busy day on the ward.

Participation in the study was voluntary, but of the nine nurses that I finally approached, none refused to be interviewed. Although there was much anxiety around the first interview, with participants being reluctant to 'go first', the feedback from the first participant seemed to reassure the others and by the third interview previous participants were pointing out nurses to me who they said 'also wanted a chance to talk'. Breakwell (1995) cautions against the feedback loop that may occur when earlier participants act as informants for later interviewees as this could lead to a distorted picture of what the interview entails. In this study the feedback from earlier participants appeared to encourage participants to engage with the process, leading to an increased openness about the research topic.

The interviews varied in length, lasting from half an hour to an hour and a half. I assured each participant that their comments would be anonymous and received permission to tape the interviews. I confirmed this again at the end of each interview. Interviews were conducted in either English or in Afrikaans. The four Xhosa-speaking participants and two Afrikaans-speaking participants spoke English in their interviews, while Afrikaans was the preferred medium for the remaining three participants. For most of the participants the interviews were therefore conducted in their second language and this factor could have affected participants' comfort with the interview situation and their willingness to talk about sensitive and emotional issues. The interview schedule (see Appendix) consisted of some demographic questions and eleven open-ended questions about participants' experiences with HIV/AIDS patients, the positive and negative aspects of their work and their sources of support, both inside and outside the hospital. In some interviews it was not necessary for me to ask all the questions and as the interviews progressed and I learnt more about the difficulties experienced by participants, I asked additional questions which were suggested by the content of the previous interviews.

The first interviews were conducted in a tiny room which nurses use for administrative work and making personal phone calls. In a sense I was offered the use of their only personal space on the ward and I soon became aware that even this space provided nurses with little respite from the noise and activity of the ward. The office was right next to the patients' dormitory and the front door, and meant that participants' voices were sometimes drowned out by screams and shouting from disturbed patients. As this affected the recording of the interviews, I eventually moved to one of the doctor's rooms at the back of the building, which was quiet and allowed for more privacy. Interviewing staff in their working environment meant that we had to tolerate some interruptions, however, even these were of value. On one occasion a nursing sister I was interviewing was talking about the difficulties of nursing patients with AIDS on a psychiatric ward. The interview was interrupted when a new patient arrived unexpectedly and the sister was called out to admit her to the ward. I stopped the interview and wandered into the reception area. The patient was an emaciated young woman, who appeared floridly psychotic and extremely restless. She waved her arms around and I noticed open sores on her arms. On seeing the sister, she went towards her and tried to hug her. Despite all my previous attempts to empathise with nurses' reactions to mentally unstable AIDS patients, it was my own immediate reaction of fear, revulsion and concern, and the paralysis arising from these conflicting emotions, which allowed me some insight into the reality of

participants' experiences. On resuming the interview after this incident, the participant initially dismissed her distress around the admission, but when I acknowledged my difficulty in simply witnessing the interaction between them, she began to talk about the anxiety and fear that such patients evoked in her.

The literature suggests that the use of appropriate self-disclosure or reciprocity on the part of the researcher can help not only to overcome participants' fears around discussing their possibly unacceptable feelings, but also places the interaction between researcher and researched on a more equal level. It thus allows for the development of a closer relationship between the interviewer and interviewee and can minimise status differences by levelling the traditional hierarchical situation in interviewing (Fontana & Frey, 1994; Edwards, 1993). I adopted this approach in the interviews and found that the interviews seemed to provide the nurses with a much needed opportunity to talk about their experiences, particularly the difficult and painful aspects of their work.

In qualitative interviews, the establishment of rapport involves not only the offering of anonymity and non-judgmental responses from the interviewer, but also that the participants feel comfortable and competent enough to talk back and offer their own insights (Miller and Glassner, 1997). The relatively unstructured nature of the interview and the willingness of participants to engage with the research topic and communicate their opinions gave rise to new and unforeseen material, as well as material with a strong emotional content. Thus participants affected the development and direction of the research process, but the interviews also affected participants. Overall, the interviews were completed over five weeks and during this time the research process seemed to generate an awareness of the anxieties around HIV/AIDS care on the ward. After my interviews with two of the participants, they informed me that they were finally putting in a written request to be transferred out of the ward. Both of these nurses had been in the ward for a year and verbal requests to be transferred had been ignored. Nurses on the ward were also discussing their experiences and feelings about HIV/AIDS patients more amongst themselves. The interviews seemed to have created a conscious awareness around previously denied or unconscious issues and while I recognised the importance of engaging with these issues, I also felt responsible for possibly increasing anxiety levels in the participants.

I also needed to consider how participants' perceptions of me as a younger person and a white psychologist could have affected the interviews. In the medical professional hierarchy, nursing staff

traditionally, have the position with the least official power, while doctors have the most authority and decision making ability (Samuelson, 1991). In South Africa, this power dynamic is further reinforced along racial lines, with nurses being primarily black and coloured, while doctors and psychologists are predominantly white. Establishing rapport and trust with participants is essential in a study with such emotive material and I was concerned that if I was perceived in the same way as doctors and psychologists in the hospital, this could limit participants' willingness to talk freely about their experiences. Two participants, both of whom were nursing assistants, did seem to regard me as an authority figure and insisted on calling me 'doctor'. Breakwell (1995) mentions that where respondents feel that they are in a less powerful or knowledgeable position relative to the researcher, they may feel silenced and unwilling to discuss their feelings and experiences openly. The differences in age, race and occupation between myself and the participants suggested that I occupied a position of social distance that included differences in relative power (Miller and Glassner, 1997). In some interviews I felt had to work to overcome suspicion from participants and that respondents were less open about their experiences because of my perceived position.

3.2.4. Transcribing

The interviews which were conducted in English and Afrikaans were transcribed verbatim. I had received a small amount of funding for the study from the UCT AIDS and Society Research Unit and the interviews were transcribed by the unit's transcriber. Once this had been completed, I checked all transcriptions for accuracy by listening to the tapes again and making corrections on the transcript documents on the computer. This was important, as the transcriber's lack of familiarity with psychiatric terminology and the strong accents of some participants, led to a number of inaccuracies in the initial transcribing process. The transcriptions included non-verbal aspects of the interviews such as pauses, as well as laughs and repetitions. The three Afrikaans interviews (nurses 5, 8 and 9) were then translated by myself into English. In discussing the constructionist approach to language, Swartz (1998, p. 28) notes that translation is more complicated than simply finding the appropriate labels for things in another language, but involves "consideration of the role language plays in determining our emotional realities". I found that some idiomatic expressions and descriptions of emotions in the Afrikaans interviews were difficult to translate accurately and that their impact was reduced by their translation.

3.3 Method of Analysis

The data from the interviews consisted of twelve hours of taped interviews, or 130 pages of transcribed interview material. In analysing the data from the interviews, I initially listened to all the interviews on tape and then read through each transcript a number of times. I made notes about different categories of information which emerged and then identified the various themes which occurred across interviews. A theme can be described as “a statement of meaning that runs through all or most of the pertinent data, or one in the minority that carries heavy emotional or factual impact” (Ely et al., 1993 p. 150). Some themes were presented by the participants, some emerged through their stories of situations with patients and other themes were created by the questions which I had asked. I then read through each transcript again, taking marked passages which indicated certain categories and cutting and pasting them under thematic headings. The next process was then to reflect on the differences and similarities in the data, to let the material suggest theories which could be used to understand it and to finally link it together to create a clear description of the topic.

Not only was the amount of data rather overwhelming, but I also felt an enormous sense of responsibility towards the respondents in terms of presenting their material in a manner which would give an accurate representation of their experiences and their views. Although I had been aware of the stressors associated with the care of HIV/AIDS patients through the literature, my intention had been to explore all participants’ experiences around HIV/AIDS care without focusing primarily on the negative. Most of the material from the interviews, however, concerned the enormous personal and practical challenges which participants had to confront in their care of patients with HIV/AIDS and the strong, often negative emotions associated with HIV/AIDS care. I was concerned that if inadequately represented, the material from the interviews could place respondents in a negative light. The failures in health services and the poor conditions in hospitals have often been blamed by the public on black nurses, and the stereotype of the cruel, bad nurse is commonly held by other medical professionals (Marks, 1994). Qualitative interviews encourage narratives which challenge social stereotypes by allowing respondents to make their actions explainable and understandable to the interviewer (Miller & Glassner, 1997) and in writing about participants experiences and attitudes I therefore needed to ensure that I presented an accurate account of their ‘cultural’ context, in this case the hospital environment, and allowed their stories to speak for them.

In chapter four I present the data by identifying and analysing the various themes that emerged in the interviews and linking this to theoretical material where it is useful in understanding and interpreting the data. Psychoanalytic theory, medical anthropological views of nursing and illness and more general theories on HIV/AIDS care were particularly useful in this regard. Nevertheless, in using theory to understand participants' experiences and in 'tidying up' the interview data through selection and categorisation of themes, I have influenced the presentation of participants' comments, telling only parts of their stories, rather than presenting them in their wholeness (Miller & Glassner, 1997; Seale, 1999). This highlights the problem of the authorial presence in qualitative research and its ability to obscure the voice of participants. I have therefore quoted participants wherever possible, rather than summarising the interview material, and this together with detailed accounts of the research process and context is an attempt to provide as realistic and detailed account of their experiences and opinions as possible.

University of Cape Town

CHAPTER FOUR: ANALYSIS

Ward 14 is the female admissions ward at Bergveld Hospital. The ward itself is situated at the far end of the hospital grounds and is part of the original hospital built in 1891. It is an old, somewhat dilapidated victorian style building which has been divided into three main areas, a dining room, a large dormitory and a day room where patients spend their time during the day. As it is a secure ward, doors are kept locked at all times. All female patients who are admitted to the hospital for psychiatric care, pass through this ward and remain there until their condition has stabilised. The ward is officially only able to take 15 patients at a time, although this is often exceeded. At the time of the interviews, 25% of all new patients on the ward who were tested, were found to be HIV positive (HIV+).

4.1. Nurses' knowledge, previous experience and awareness of HIV/AIDS

All participants in the study expressed an awareness of HIV/AIDS, although nursing sisters appeared more confident about their knowledge of the viral nature of the disease and modes of transmission than senior nurses and nursing assistants. Participants were asked if they had received any formal education or training around HIV/AIDS and nursing care in this context. Of the nine nurses interviewed, only one had received any formal education about HIV/AIDS in the form of a seminar covering facts around transmission, organised by the hospital. Although this seminar was mentioned by most of the respondents, they reported that they had not had a chance to attend due to staff shortages and practical difficulties in terms of getting time off from the ward. Mention was also made of a training course which nurses were being sent on outside the hospital, but none of the respondents had as yet attended. Respondents reported that their general information about HIV/AIDS was obtained from colleagues, especially nursing sisters, television, educational pamphlets or, in one case, her own research.

Previous experience of working with HIV/AIDS patients and developing longer care relationships with them, have been found to reduce the fear of such patients, thus increasing positive care experiences and a willingness to provide care and treatment amongst nursing staff (Berkowitz and Nuttal, 1996; McCann, 1997). Participants were asked if they had nursed known HIV/AIDS patients before working on this particular ward. All respondents had been working at Bergveld Hospital for a minimum of eight years, and previous experience with HIV/AIDS patients was found to be restricted to their experience within the hospital. Most nursing staff said they had had some

contact with known HIV/AIDS patients within the wards during the last five years, although only two respondents reported sustained contact with HIV/AIDS patients. The first said she had worked with HIV+ patients in a longer term psychotherapy ward and the second respondent reported working on an HIV/AIDS ward within the hospital which had been established specifically for such patients. This ward had, however, since been closed and patients had been integrated back into the general psychiatric wards within the hospital.

It became apparent in the interviews, that most of the participants had, until a few years ago, been relatively unaware of patients having HIV/AIDS. When asked, the majority reported that they had become aware of HIV/AIDS in the patient population within the last five years, although two respondents stated that they had only become aware of such patients since they had joined this particular ward last year. In the latter cases their awareness appeared to have been prompted by the visible, physical symptoms of patients with stage four AIDS, as this nurse indicated:

Mostly here in this ward, like that one patient who came in the other day, where I could see her condition was bad... and if the doctors show you a patient and say that one has AIDS, but you won't necessarily see the symptoms because they still look okay (Nurse 9, senior nurse).

Another nursing sister indicated that this increased awareness of HIV/AIDS has also increased the level of caution in their work with patients.

I've mainly realised it in this ward. They've been here since about 1996, but at that time I didn't know anything about AIDS, we were not so cautious like we are now. So actually they were here for a long time before we became aware of it, at least I only became aware of it recently (Nurse 2, nursing sister).

Participants were also unanimous in their perception that the cases of HIV/AIDS were on the increase. Nurses mentioned that at one stage last year, a third of the patients on the ward were known to be HIV+, and not all had been tested. As one participant indicated: "Now it's becoming worse because... it's like last year it was like two patients [in the ward], now it's like ten" (Nurse 3, nursing sister).

In summary, only two participants reported previous experience with HIV/AIDS patients in other wards, and in both cases the diagnosis of an HIV+ status or AIDS was central to the patient's

reason for admission. For the remaining respondents HIV/AIDS had, until recently, been an invisible presence, whose existence could easily be overlooked. The change in awareness appears to be linked to an increase in the number of admissions, as well as an increase in patients who are at an advanced stage of the illness, rather than just being HIV+. This awareness has also led to HIV/AIDS patients being treated with more caution than before. Training and information regarding AIDS is also likely to increase awareness and allow nurses to protect themselves and other patients from infection. This has, however, not occurred and some staff appear to have only a very limited understanding of the HI virus and its transmission. This is discussed in more detail in the following sections.

4.2. Difficulties experienced in the care of HIV/AIDS patients

Although most participants felt that they had a duty to care for patients with HIV/AIDS, they said they often felt overwhelmed by difficulties involved in providing this care, including ensuring their own safety and the safety of patients on the ward. The following five themes have been taken from the interview material to highlight the challenges the nursing staff on ward 14 described around the nursing care of HIV/AIDS patients. The fear of contagion will be dealt with first as it underlies most of the difficulties mentioned by participants.

4.2.1. Fear of contagion

The fear of contagion was a recurring theme throughout the interviews and was mentioned by all nursing staff as a difficulty in their care of patients with HIV/AIDS. Due to the different functions performed by nursing sisters and general nursing staff, the risk of infection and awareness of it differed to some extent between the two groups of respondents. Nursing sisters have limited direct contact with patients and interact with them primarily during the initial admissions and the tasks of administering medication, sedating patients and drawing blood. Their awareness of the possibility of infection was therefore heightened when aggressive patient behaviour occurred during high risk activities, such as drawing blood. Some sisters reported that at other times, they tended to forget about the issue of HIV/AIDS, as one nursing sister said:

It's only when something happens to a certain patient and she performs in certain manner that it strikes me, on my mind, oh by the way, you know? It's not like all the time that I think about AIDS (Nurse 3, nursing sister).

For this nursing sister, concerns about contagion are present primarily when a patient's behaviour is experienced as directly threatening or potentially violent. Although working with patients

suffering from a contagious disease suggests that nurses should maintain an awareness of the possible dangers in order to take the necessary precautions, some nurses said that they “forget” about HIV/AIDS. This suggests that nurses may defend against the anxieties associated with HIV contagion by denying the illness until a situation occurs which reminds them that they may have been in danger.

In contrast to this, other nursing sisters said they were constantly aware of the risk of infection, particularly to the nursing staff under their supervision.

Our working environment is not safe at all, you just pray that you don't get infected. You just take the necessary precautions. Like now, I search all the nurses, they must have gloves, those heavy duty gloves... it doesn't matter who they touch and they must touch them with gloves (Nurse 4, nursing sister).

Miller (2000) has suggested that decisions about risk behaviour in the context of very low probabilities will either be ignored or strongly over-emphasised. As yet there have been no known staff infections on ward 14 and yet the risk of contracting HIV/AIDS is seen as very high by this participant. Her suggestion that all nursing staff should wear heavy-duty gloves when touching patients seems extreme, and is also in direct contrast to her own admission later in the interview that she herself does not wear gloves.

The views seemed less divided amongst participants in the general nursing group and they mentioned a constant awareness of the risk of physical infection due to their ongoing contact with patients. Their tasks of bathing, feeding and generally taking care of patients' everyday needs brings them into close physical contact with patients and their body fluids. Some of the nurses reported that they were not overly concerned with the risk of HIV infection if patients were calm, and they regarded their constant awareness of their physical safety as part of their work on an admissions ward with potentially violent patients. Other participants in the general nursing group, however, were concerned about general contact with HIV+ patients, not only in terms of being infected with the HI virus, but also due to a fear of contracting something “dirty” from the patients. While this may have referred to other infections, the fear of physical contagion also seemed closely linked to more irrational fears that went beyond physical infection and appeared related to a fear of the stigma associated with HIV/AIDS patients. As one nurse reported:

You worry about it [infection]... because sometimes you forget for example that you worked with those [HIV+] patients, and then you go home and you've only washed your

hands. Now you just carry on and your children come and hang on you, and I mean maybe by that time you haven't even changed your clothes and you don't know if you're still dirty or things like that (Nurse 9, senior nurse).

The suggestion in this comment is that the fear of infection is not related to the HI virus, but rather a sense of being infected with the stigma, 'dirt' or possibly unknown diseases associated with the HIV/AIDS sufferer. Another nurse also expressed a similar fear of 'dirtiness', that seemed to go beyond the objective risks involved in contracting AIDS from direct and immediate exposure to body fluids:

As a human being you feel... As a nurse I don't want them to suffer, but as a human being I don't want to eat out of that same plate. As a human being you think a lot of things but you know it doesn't work like that, but still ... you know it's not nice especially when they spit, you don't want to walk there because you don't want to touch it. When they have their periods and they sit on the chairs we must all sit on the chairs now you know that one sit there and you don't want to sit there because you feel that person is dirty (Nurse 6, senior nurse).

This comment suggests that in her professional capacity as a nurse the participant is aware that she should not discriminate against patients and yet her fear is there and she attributes it to the part of herself that is simply a 'human being'. Both these views seem surprising in nurses who one might expect to be familiar with a realistic understanding of viral contagion. Nursing sisters also seemed aware of these fears and expressed their concerns about HIV/AIDS knowledge amongst the nursing staff. As one sister commented:

People they want to protect themselves against a contracting the virus, you understand? And I've discovered that most of the staff members especially the lowest category nurses, they don't actually know.... they not aware how it gets transmitted and how it doesn't get transmitted. Petty little things like taking the cup and then they will scrub that cup and clean it, I said no, you won't get AIDS from this thing, you don't get AIDS like that. Then you find that there is a patient and then they remove themselves from that patient and they are too extra careful and sometimes it becomes obvious to the other patients (Nurse 4, nursing sister).

Comments such as this one suggest that senior nurses and nursing assistants, who receive their training at the hospital, rather than through a nursing college or university, are perceived by some of the nursing sisters as having irrational fears about HIV/AIDS contagion and thus discriminating against patients. This is supported to some extent by comments made by those staff members

themselves, but perhaps not all staff were able to be this honest about their negative feelings towards patients. Indeed, further comments by nursing sisters suggested the possibility that their own similar unacceptable, negative feelings about patients were attributed to “lower category staff”. This is supported by Menzies Lyth’s (1960) theory that nurses may split off negative aspects of their conscious personality and project their own attitudes and impulses onto junior staff members in order to defend against the anxiety evoked. Thus, the internal conflict can be externalised and blamed on less powerful members of the nursing group.

All nine participants reported feeling threatened and at risk of infection in cases where HIV+ patients, or those thought to be HIV+, were violently psychotic and/or displayed the physical signs of advanced AIDS. Fears of contagion were strongest in these situations and this will be discussed in more detail in later sections of this chapter.

The fear of contagion amongst staff raised questions about the risk of infection and whether staff were following appropriate prevention measures in their work. These measures include safety regulations for the use of needles and the wearing of gloves. A two page list of infection control guidelines, which should have been visibly displayed in the ward, was only produced when I requested it and was then immediately filed away again. Participants reported that the risk of infection made them more careful with regard to their physical contact with patients but, at the same time, most of the participants seemed ambivalent about using gloves to protect themselves. As one nurse said:

I really don’t mind working with them [HIV/AIDS patients]. You just need to take the necessary precautions. Usually we have to wear gloves, but we don’t wear gloves... but if you don’t have a open wound on your hand then it’s ok, it’s fine. You just have to make sure the patients don’t fight (Nurse 5, senior nurse).

This participant suggested that contagion was not an issue if precautions were taken and then appeared to contradict herself by admitting that she does not take the necessary precautions. Of the nine nurses interviewed, only one said that she always wore gloves in her nursing duties with patients. The other eight participants acknowledged that wearing gloves was important, but admitted that they seldom wore them, although some said they would sometimes wear them if they were working with a known HIV/AIDS patient. Their attitudes towards wearing gloves, a precaution which is regarded as essential in the nursing care of AIDS patients, was in stark contrast

to the fear of contagion expressed by nurses. Knowledge of prevention of occupational risk in HIV/AIDS care, however, has been found to be unrelated to prevention behaviour (Miller, 2000).

Some of the reasons for failing to adhere to precautionary measures prescribed by the hospital are mentioned by the staff in the following quotes:

Whether or not you've got the gloves there are times when things do happen without you thinking that now this is a particular situation, you cannot be wearing gloves all the time.

Like if there is a need for you just to help out and not think about gloves, so in such cases you are not blaming the hospital for not having equipment or not equipment, equipment can be there but you still do not get a chance of using it (Nurse 3, nursing sister).

McCann (1998) found that adverse working conditions may lead nursing staff to consciously dismiss the risks involved in caring for patients with HIV/AIDS in order to meet the demands of their work. This seems to be reflected in the above quote, where a nursing sister mentions the need to respond quickly to a situation, without having the time to consider the possible risks involved. The literature also suggests that people have a subjective sense of immunity when performing familiar tasks, and will disregard the risks they may be taking in order to remain focused on the task at hand, particularly in stressful situations (Douglas, 1985).

The nurses also seemed concerned that wearing the gloves available on the ward could impede the physical dexterity required in some nursing tasks. This is reflected in the following comment by one participant: "I can't work with gloves. I become too clumsy and most of the time you will never get the gloves that fits you nicely you know" (Nurse 4, nursing sister). Tight-fitting, latex gloves are often not available on this ward or are not available in the right size. Nurses must therefore use thick, plastic cleaning gloves when bathing patients and as another nurse explained, these are ineffective in protecting them against patients' body fluids. "Most of the staff don't like them, because they are the floppy kind [of gloves]. They don't fit and the water runs into the sleeves... if you wear them or not, it makes no difference" (Nurse 9, senior nurse). In relation to this, studies have shown that inadequate facilities and resources, such as ill-fitting or inappropriate gloves, may compromise attempts to adhere to infection-control guidelines (McCann & Sharkey, 1988). A final reason given by participants for not wearing gloves, was that as psychiatric nurses they were simply not used to working with gloves and found them uncomfortable. Another possible reason for nurses' risk-taking behaviour could be related to a denial of the fear of contagion. This would

allow unacceptable feelings and fears to be controlled by behaviour patterns which are directly opposed to them, in this case, a failure to wear gloves.

Only one participant insisted that she wore gloves and gave her awareness of the risk of infection as the reason. "I do, I do, I really do [wear gloves]. You know, I have such an awareness of safety. One of my cousins she's just been diagnosed with HIV" (Nurse 7, nursing sister). There is of course no way of knowing whether this represents her behaviour, as people are often likely to under report their risk-taking behaviour (McCann & Sharkey, 1998).

The general awareness about patients having HIV/AIDS and fears regarding physical contagion therefore seemed to vary amongst the participants, possibly due to their different levels of contact with patients. All the participants, however, reported that they feared HIV infection in situations where they felt threatened by violent patients or had to nurse severely physically ill AIDS patients. With some staff in the general nursing group, the fear of contagion also seemed connected to a fear of the stigma associated with HIV/AIDS and a perception of such patients being carriers of disease or dirt. In contrast to the fear of contagion, nurses seemed to engage in risk-taking behaviour by not wearing gloves in all the required situations.

4.2.2. HIV - the invisible threat

Patients are admitted to ward 14 through a number of routes, including referrals from other hospitals or clinics, or simply by being brought in by family or the police. A patient's HIV status is therefore not always known at the time of admission, and may in fact go undetected unless the patient's mental state requires physical investigations and the patient has given permission for testing. HIV testing may be more easily done with new admissions where investigations are warranted to determine the cause of mental illness. Psychiatric patients who have a history of multiple admissions are therefore less likely to be tested and their HIV status often remains unknown. The uncertainty about patients' HIV status was reported by staff as a difficulty in the work. Nursing staff reported how not knowing the HIV status of a patient put them at risk. They would often only think about the possibility after they had been exposed to infection and then experience anxiety and fear about possible consequences after the event. As one nursing sister stated:

Now the fears only come when we think, by the way it can be still an undiagnosed somebody ... this is threatening. I get that fright you know? Because most of the time... ok,

there are the known ones who when they come in maybe you have nursed this patient before, or maybe you get also a referral which states that the symptoms are HIV. But some of them are not diagnosed. Then you think that you are working on an innocent somebody then when it does happen that the doctor decides to do the HIV test, then you think, what happened between me and this patient that night? So now you cannot predict whether they have been diagnosed HIV or not. There are certain emergencies that you don't even think... you are just thinking about helping out the patient, you see. Only afterwards then another nurse says do you know, that patient is HIV positive... so you don't know your safety, you cannot guarantee that you are safe (Nurse 4, nursing sister).

This last extract highlights the difficulties around not knowing the HIV status of patients. Nurses are sometimes only reminded of the risk of possible infection only once a patient has undergone the testing for the HI virus and is found to be HIV+. This causes an anxiety about what interactions may have taken place with a patient who was initially thought to be "innocent", but is now found to be infected.

Some nursing staff, however, said that all patients needed to be treated as if they had the HI virus, as indicated by this nursing sister's comment:

We don't know exactly which patients have HIV, so we have to treat, unfortunately everybody else as if they have HIV/AIDS. Which is also unfortunately not good for people's human rights quite unfair, very unfair (Nurse 7, nursing sister).

This sister's comment also suggests that treating patients as if they are HIV+ infringes on their human rights and this indicates, that on some level, patients with HIV/AIDS are treated differently. In the responsibilities of their work nurses are often confronted with situations which evoke conflicting emotions (Menzies Lyth, 1960). In this case the duty to care for patients may be in direct contrast with fears surrounding being infected with the HI virus through their contact with HIV+ patients. Nurses may therefore defend against the anxiety caused by this conflict (Menzies Lyth, 1960) and this raises concerns about possible discriminatory nursing care in the form of avoidance of patients (McCann, 1999).

Nurses also mentioned the anxiety and distress caused by incidents with patients in which they came into contact with a patient's body fluids and feared contagion. In one particular case, which was mentioned by most of the nursing staff, a young woman was brought in from the street by the police. She was in severely neglected, dirty and floridly psychotic. At the time of admission her

HIV status was not known. Four nurses and a security guard took the young woman to the showers to wash her and while they were not looking, she soaked her used sanitary pad in water and threw it at the staff, splattering them with her menstrual blood. Although some of the staff thought that the patient was later discovered to be HIV positive, others said that she was never tested. One nurse recounted her experience of the incident:

She was standing under the shower and we didn't know she opened the tap and we were standing near and then she wet her sanitary pad like this and we didn't see and then she just throw me full of blood, but I thought it was water and then my eyes was full of blood, my whole face, and I was wiping, but I thought it was water but the next minute I saw everybody was full of blood, then I realised it was blood she was throwing in my face. I was immediately upset we were all upset that day, we came out, we had to wash our tops, I had to take everything off, my bra my panty, everything, because the security [guard] she also fall in that blood and she slipped and she fell, oh... we are dirty, you feel dirty, because you know she is from the street and you can expect anything from her, although maybe she doesn't have it but you think that, you know (Nurse 6, senior nurse).

Although the HIV status of this patient was not known, her visibly dirty and neglected physical appearance suggested to the nurses that she could be HIV positive. Again the association is made between HIV and people who are physically dirty and the patient is spoken about with a sense of revulsion. This particular participant's distress and fear about the incident are evident in the above quote. The patient's unexpected behaviour appears to have left the participant feeling deeply shocked and her emphasis on feeling dirty after the incident suggests that there is a feeling of being tainted by the patient's blood, a feeling which goes beyond the physical threat of infection. Another nurse also referred to the same incident:

Like in the case of that girl who threw a dirty sanitary pad at us, I mean, actually you get scared because I mean it's in your eyes and it could have been in your mouth and things like that. It actually frightened us. Yes, it makes you nervous, very nervous and if you're not deeply, not properly or well informed about HIV then you don't actually know... I mean, you know, how dangerous it is... that's why we try not to think too much about it because we're not well informed about it (Nurse 9, senior nurse).

This comment by a senior nurse captures an important aspect noticed by the interviewer, namely the tendency not to think too much about the issues and concerns about HIV/AIDS on the ward. The quote suggests that the participant was afraid about the possibility of infection after the incident, but at the same time, was not completely sure whether her fear was justified. According

to participants, no debriefing occurred after this incident and management did nothing to support staff around their anxieties. Studies have found that the continuing fear of contagion has been linked to the tendencies of hospital administrations to downplay the risks associated with the nursing of HIV/AIDS patients (Gerbert, 1988 as cited in Bellani et al., 1996). Thus, insufficient information regarding the risk of contagion in the incident mentioned above, an apparent lack of concern from management, and the patients unknown HIV status, may have added to the anxiety and uncertainty experienced by this participant.

The invisibility of the HI virus and the uncertainty about patients' HIV+ status thus evokes a range of responses from nursing staff. While some treat all patients as if they may be HIV+, this could lead to discriminatory care. Others are reminded of the possible threat of HIV infection only after incidents where they come into contact with patients' body fluids, or when the patient is finally diagnosed. Anxieties about the risk of infection do not seem to be addressed after such incidents and this appears to result in a tendency in staff to deny their fears and to avoid thinking about them.

4.2.3. Caring for mentally ill patients with AIDS

While HIV+ patients seem to have an 'invisible' disease, patients with full blown AIDS have clear physical signs of their illness. The visibility of AIDS, the physical suffering of those patients, as well as the difficulties associated with caring for severely ill or dying patients on a psychiatric ward, were mentioned by all respondents. The fear of contagion, both for the staff and other patients, was strongest in situations where the illness was visible and the patient's physical deterioration required close contact and care from the nursing staff. The daily nursing care of patients is the responsibility of nursing assistants and senior nurses, and respondents in this category reported feeling unhappy, anxious and overwhelmed by the responsibility and the fear of working so closely with AIDS patients in a ward with little equipment. Fear seems to be the most powerful response to such situations, as one nurse described:

I feel very unhappy sometimes [about working with AIDS patients]. Like when they have diarrhoea and things like that. You know, we get scared and you must be careful with everything that you do and all that. It worries you (Nurse 1, nursing assistant).

Another nurse also described her feelings about nursing a patient with stage four AIDS:

Like that one... D, she was HIV positive and she had a bad bad case, she was so thin, and the last day when she here in this ward, before we sent her to the clinic, she had a running tummy, and oooh we couldn't stand it, how can you keep this patient in this ward, she was

smelling and the flies was all over us. She was really like a dead body already, and it was stinking, we couldn't stand it, but we had to wash her, and as we washed her, it [diarrhoea] was pouring like an open tap, and we had to work with her... and then you go home you just feel you want to go into a bath, you want to wash yourself off you feel dirty, you feel upset you feel everything, but what can you do, nobody take notice. That is your job you must just do it, tomorrow you come to work, you must just work with her again, you can't say no (Nurse 6, senior nurse).

In this comment the nurse's reluctance to work with the patient and her revulsion at the patient's physical conditions are apparent. There is a sense from the extract that she is unwilling to work with the patient, but feels that she has no choice in the matter. The extract reflects no apparent concern for the dying patient's suffering and none was mentioned later in the interview. In fact, the patient is referred to as being a 'body' and this suggests that the patient has been depersonalised, a defence mentioned by Menzies Lyth (1960) used to create distance between nurses and patients in order to defend against the anxieties evoked by work of such a distressing nature. Psychodynamic theory suggests that nursing a dying patient who is mentally unstable and has a contagious disease is likely to evoke enormous anxiety and primitive fears of being damaged through contact with the patient. The participant's feelings of having been contaminated by the patient are reflected in her need to wash after work. This episode was obviously distressing for the participant and yet she felt that her distress was neither acknowledged nor noticed.

One participant mentioned her concern for a patient with AIDS, as well as her own fears about nursing her:

The one [PWA] on the ward at the moment, she's very weak and sick. And the problem is she has sores in her mouth, we don't have special food for her. She also uses the same spoons that the other patients use. I don't know if the kitchen staff put it aside... it's a problem (Nurse 9, senior nurse).

This nurse mentioned her concern about the fact that despite having severe thrush, the patient had to eat ordinary hospital food, which could be painful and difficult in her condition. At the same time, she feared that the patient's spoon may be used by others and saw this as a problem. The concern about providing adequate care is therefore compounded by the perceived danger which this patient could pose to others.

A number of participants also voiced concerns about AIDS-related illnesses. They felt that they were at risk of contracting illnesses such as Tuberculosis and were not sufficiently protected from this in their work environment. As one nurse stated:

We feel scared and like me, I don't have a medical aid. Now these TB cases that we get... you think you're fine and then the winter comes and you have a cough and you doctor it yourself and go on. Later, the... like that other nurse who we lost last year because she contracted TB (Nurse 5, senior nurse).

Nursing staff, especially the nursing sisters, were also frustrated by the lack of facilities on the ward and the conditions under which they are required to care for physically ill patients. They reported feeling ill-equipped to deal with medical emergencies which could arise in the case of a patient with advanced stage four AIDS. Staff reported feeling frustrated at having to borrow equipment, or simply manage without, and the following comment by one participant suggests that the ward does not have the ability to provide the type of care which patients need.

We don't even have equipment here when the doctors ask for something, then you realise you don't have this thing, then you must run to the clinic to get the equipment or you must run to ward one to get that equipment. It's very difficult, because this ward is not equipped for physical things, it should be, but it's not. I don't know why. I know it's suppose to treat people in totality not just for mental illness, but that patient needed a drip, we don't have that (Nurse 4, nursing sister).

The sisters also struggled to have restless or psychotic AIDS patients admitted to the clinic (physical ward at Bergveld Hospital). In the following comment a nursing sister explains the difficulty of coping with physical illness on a ward intended to treat mental illness.

Right now there is an admission that is like very very thin, stage 4 AIDS, she has just walked in, number one she is too thin to be in this ward, and there are people that are so mad that they will probably fight with the patient. You know it is difficult in the sense that this actually a ward for mentally unstable patients. And you have to deal with a combination of physical and mental. If a patient is quite frail as she is, she would go to ward 18, the clinic, but now she's aggressive, and the clinic will send her back, unless she can be stable (Nurse 7, nursing sister).

Staff are therefore faced with the dilemma of having to admit patients who require intensive physical care because they are not mentally stable enough to be referred to a physical ward.

However, the conditions on the ward and lack of facilities make it difficult to provide the care which the patient needs and, according to the sister, the patients' aggressive demeanour and her physical appearance are likely to elicit angry responses from other patients. The interview with this sister was interrupted in order for this patient to be admitted and her concern and anxiety about the admission were evident.

Confrontation with death and dying is also inevitable with AIDS patients, an experience which is common in medical wards but unusual in a psychiatric ward. Patient D, who had been in and out of ward 14 for months, was finally admitted while she was dying of AIDS. A few days after the staff finally managed to get her admitted to the clinic, she died. All the respondents who had been on the ward at this time (two months prior to the interviews) mentioned this case in their interviews. Some referred to it with a sense of relief at her death, in part because nursing her had been difficult, but also because nursing staff felt helpless to improve her situation or treat her with medication. As one participant reported:

I was happy. I won't get upset if somebody dies of HIV who's been suffering especially for people like her, no I won't because really it was time for her to go. She had no family, no one to take care of her, and there was no quality of life so why must she live? Ja, it's a normal thing because our job is to save lives but sometime I mean, everyone has to die. No, I was very happy when she died. Not like happy happy, but relieved, because there was nothing to treat her for (Nurse 4, nursing sister).

The futility of treatment is often mentioned as a stressor in AIDS care (Miller, 2000) and appears connected to feelings of inadequacy in nursing staff who work in a hospital system which aims at curing patients and preserving life at all costs (Stokes, 1994).

A number of nurses, however, mentioned the shock of having a patient dying a few days after leaving the ward, and this is illustrated by the comment from another nursing sister:

It doesn't matter whether she has HIV/AIDS you know? A person is a person, you do feel these things. You do feel, especially like our patients they seldom die, if they do die you do feel... you do get hurt in a way, its not like in the general hospital (Nurse 2, nursing sister).

As the number of AIDS cases increase, reactions of shock and grief are likely to be a more common occurrence and staff will more than likely have to deal with the added stress of bereavement overload, a stressor experienced by nurses and health professionals in the field of AIDS care (Miller, 2000).

The above comments indicate the difficulties experienced in the care of AIDS patients on a psychiatric ward. Nurses are expected to provide care for physically ill patients and dying patients, but feel they do not have the equipment and resources to provide this care or to effectively protect themselves against the risk of infection. Participants' comments indicate their fear of AIDS patients and although some of this appears to be around the issue of physical contagion, the visible signs of AIDS are also a constant reminder of death. In nursing terminally ill patients it is inevitable that nurses will identify with patients and be constantly reminded of their inability to prevent death, in their patients and themselves (Speck, 1994). Coping with death and physical illness in AIDS patients are also new challenges for nurses in psychiatry, and this may to some extent explain the tendency shown by some participants to depersonalise patients in an attempt to defend against the anxieties evoked by the work.

4.2.4. Violence, psychosis and HIV/AIDS

Eight of the nine respondents interviewed mentioned the difficulties they experienced in caring for psychotic patients with HIV/AIDS. The containment and care of patients with psychosis and an infectious, terminal illness was experienced as very stressful and an enormous responsibility. As ward 14 is an admission ward, and often the first point of intervention, patients can be in state of extreme agitation and confusion on their arrival. As one nursing sister said:

Patients are unpredictable when they are here, they can be wonderful the one minute, and you know they are good people, but when things take them and they start hearing voices, you know, they can turn around and be aggressive or frightening within minutes (Nurse 3, nursing sister).

Participants indicated that the difficulties invoked by nursing patients who exhibited unpredictable, aggressive behaviour due to a psychotic illness were exacerbated by the threat of HIV infection. Severe behavioural disturbance is also a clinical feature of HIV related psychosis (Saunders, 2000) and patients can experience very vivid visual hallucinations and exhibit aggressive behaviour. Nurses reported a range of situations in which they felt threatened and unsafe with aggressive HIV+ patients. As one nurse said:

The most difficult thing is the aggression, and disruptive behaviour. Some of them they become depressed and become more tearful at least that is not so bad because that person can come far, but a disruptive patient can disrupt everybody. How do you handle that person? and during that act of handling that person you might contract HIV yourself. I remember the other day I had to go and inject F. and it was so difficult to inject her. You

put the needle in already, then she jumps off and that needle has been into her already... if you can prick yourself with this needle on your hand... so it becomes more difficult with disruptive patients, better when they are depressed then you can comfort them and you can talk to them (Nurse 4, nursing sister).

Needle-stick injuries, and the resulting possibility of HIV infection, are a common concern amongst nursing sisters and there had been a number of such injuries on the ward in the year prior to my interviews. Fortunately none resulted in contagion. As can be seen from this excerpt, the dangers involved in treating restless or aggressive HIV/AIDS patients result in these patients being seen as difficult, whereas HIV/AIDS patients who are depressed are seen as less threatening. There is also a sense that the depressed patients can be comforted, that the staff can do something to ease their situation and relieve their emotional pain. This supports comments made by Bennet et al. (1996) which indicates that where nurses are able to connect with patients on an emotional level and provide some support, they are likely to experience a sense of achievement and reward in their work, which may mitigate against the experience of stress.

Nursing staff also reported that they feared contagion in situations where patients known to have HIV/AIDS acted in a manner which seemed purposefully spiteful. As one nurse described:

It's when a HIV patient is so disruptive that they spit onto you or maybe tries to bite you or tries to scratch you and there's time like when one takes a sanitary pad with blood, it's only those things that makes you scared (Nurse 3, nursing sister).

Many of the respondents not only seemed to think that HIV/AIDS patients suffering from psychosis were more aggressive than other patients, but that they actively wanted to spread the disease. Other participants confirmed this view, saying:

Ja, they are more aggressive [than other patients]. They do all these strange things they are sexually disinhibited, it's like they use all this, that idea of transmitting the disease, I don't know why, they become extremely aggressive, ja, they attack patients and scratch people, they become sexually disinhibited and it's like fights and all those things. It's like subconsciously they it's like they want to spread the disease in some way or the other, although they are not maybe intentionally doing so (Nurse 4, nursing sister).

The perception that patients actively want to infect others with the HI virus adds another dimension to the threat of contagion and to nurses' feelings of responsibility about the physical containment of the illness on the ward. Aggressive HIV/AIDS patients appear to be regarded with caution and even fear, although this participant recognises that the perceived motivation for their

behaviour is not necessarily conscious. Another respondent, however, seemed to think that such behaviour was conscious and deliberate:

But she was always, how shall I say it, she did things on purpose, she knew exactly what she was doing... negative things that she knew she shouldn't do. Like she would maybe, like spit in the other patients' coffee or she comes past and she spits in your face... You get angry, because she knows exactly what she's doing, but what can you do? You just clean up and go on, there's nothing you can do (Nurse 8, nursing assistant).

This quote also indicates the anger and helplessness experienced by this nursing assistant in response to apparently deliberately spiteful behaviour by an AIDS patient. Here the understanding is that the patient was aware of her actions and it is possible that patients sense the fear and avoidance of nursing staff and act in a deliberately provocative manner in order to elicit a response. A comment by another participant illustrates this point:

It's difficult to work with them sometimes, like that one patient... she knew she had AIDS right? And she had her period and bled into the bath and she refused to get out or to take the plug out of the bath. At that time she was very ill [psychotic] and that day we, it was a terrible day because we had to pull out the plug but the whole bath was full of blood (Nurse 9, senior nurse).

It is possible that this patients' behaviour forces nurses to interact with her and to come into contact with her body fluids and, in this case, the possible risk of infection. The fear that this event evoked in the participant is clear from the quote and may well reflect the fear experienced by the psychotic AIDS patient in question.

The above quotes reflect the difficulties experienced by staff in the care of psychotic patients who exhibit aggressive or intrusive behaviour and are either HIV+ or have the visible signs of AIDS. HIV/AIDS patients are perceived as more aggressive than others and the fear of physical threat is exacerbated by the fear of contagion, particularly where patients are seen as actively wanting to spread the disease.

4.2.5. Responsibility for the safety of other patients

Nursing staff expressed concern about the safety of other patients on the ward and their feelings of responsibility towards those patients. One respondent said she doubted the quality of care she was providing for other patients and explained by saying:

It's difficult to say here's your face-cloth, keep it, it's yours, here's your toothbrush it's yours keep it, you know, you will use it, and share with that one. To be honest the kind of nursing in which I am involved in in this ward is part and parcel of making the situation worse (Nurse 7, nursing sister).

This participant expresses concern about her ability to protect patients from contracting the HI virus. There is little control over such things as the sharing of personal effects such as toothbrushes and face cloths between patients, and the hospital often cannot issue enough of these to the ward due to financial constraints. This nursing sister sees her nursing care as ineffective in terms of containing a contagious disease and feels responsible for the situation on the ward.

Most participants expressed concern about the possible risk of contagion among patients, primarily because of fighting and aggressive behaviour. There was a general feeling of despondency about the situation, with nurses feeling unable to contain and protect others from the disease. As this nursing sister noted:

There are a few where you can see that the patient is aware of having HIV but is also like biting the other patients, you know. You stay with those guilt feelings you know, right now even if it's not you it's the other patient innocent patient, you still feel you know, you don't feel good about it, then only you think ag, this HIV this AIDS business is just gonna you know, we will end up all having it (Nurse 3, nursing sister).

This participant mentions her feelings of responsibility towards protecting patients from attacks by HIV/AIDS patients and the guilt she experiences if she is unable to do so effectively. There is a sense in her closing sentence that she feels powerless to prevent contagion of HIV in the ward and that the situation is, or will become, out of control.

Patients' reactions of fear and distaste towards HIV/AIDS patients were also mentioned by a number of staff members. As one nurse said:

Sometimes the other patients also they can see, when they say 'I know you got AIDS, I don't want to sit next to you'. Then you can really see, they don't want to mix with them, they don't want to sit or eat at one table because they just think no, you've got AIDS and especially the sick ones. But sometimes I also feel it's not nice because we got AIDS patients here and then the others must eat out of one plate, I mean its not that will give the them AIDS but still you know? Me, if I must get mad now, sick and I must go to an institution like this, you mix with the infected patients, and you must eat with them, you

must sleep with them, you must share everything your face cloth with them, they must share sometimes the tooth brushes because there aren't enough (Nurse 6, senior nurse).

This comment indicates that the nurses believe that other patients in the ward feel uncomfortable to associate with known HIV+ patients and especially AIDS patients whose physical condition is visible. Their attitudes, as described by this senior nurse, indicate that HIV/AIDS patients are, at times, discriminated against and shunned by their fellow patients. The nurse sympathises with their attitude and suggests that she would feel the same way if she were a patient in the ward. Although she acknowledges that AIDS is not contracted through sharing eating utensils or sleeping in the same ward, she shares the other patients' concern about associating with and sharing a daily living space and facilities with HIV/AIDS patients.

All the respondents commented about their feelings of responsibility towards other patients to protect them from contracting the HI virus. The lack of facilities on the ward and aggression amongst patients were given as reasons for their concern, but some staff also felt that it was not appropriate for other patients to share the same living environment as those with HIV/AIDS. These aspects again highlight the difficulties of the care of patients versus the containment of a contagious disease.

4.3. Willingness to nurse HIV/AIDS patients

The previous section focused on the difficulties which participants mentioned in their care of HIV/AIDS patients. Most of these difficulties reflect a fear of contagion and/or a fear of the stigma associated with HIV/AIDS. This suggested that staff felt ambivalent about HIV/AIDS patients and raised questions about their willingness to provide care. Participants gave a range of responses to a question about how they felt about nursing the increasing number of HIV/AIDS patients on ward 14. Some acknowledge the difficulties they experienced, but felt that they had no choice in the matter. As one nurse said:

No, I didn't want to say no [to nursing a PWA], but it wasn't a nice feeling, because I know I can't refuse, there's no way that I can refuse I must just work with her (Nurse 6, senior nurse).

Although this nurse would not refuse care to a patient, she expressed some reluctance about working with AIDS patients, something which she feels compelled to do, regardless of her preference. Later the same participant suggested that HIV/AIDS patients should be cared for in a separate ward and then admitted that staff would not want to work there:

If they can maybe open a special ward for AIDS patients here, it will be nice but the staff maybe won't work there, you know, because they will know now everyday they must come in just to work with the AIDS patients, it's not nice (Nurse 6, senior nurse).

McCann (1999) found that although hospital staff will not refuse care to HIV/AIDS patients, issues of contagion and the social stigma associated with AIDS often lead to a reluctance to provide care. The danger in such situations is the possibility of discriminatory care of HIV/AIDS patients, as they may be perceived as less deserving than other patients. McCann's observations are apparent in this participant's comments. She will provide nursing care because it is expected of her, but if she were given a choice she would not work in a ward with HIV/AIDS patients. Half the respondents (those in the group consisting of senior nurses and nursing assistants) mentioned at some stage during the interview that a separate ward for HIV/AIDS patients should be considered, particularly when patients were psychotic, restless and violent. Most of these respondents, however, were not prepared to work in such a ward and only two participants said they would be willing to work in such a ward, if it were sufficiently equipped to provide for patients' physical and mental needs.

HIV/AIDS patients were also described by staff as an added burden in an already stressful, overcrowded ward. As one nurse said: "Sometimes a person gets angry, because every second patient that comes in has that illness, but there's nothing we can do about it" (Nurse 8, nursing assistant). Although their presence was accepted because staff felt there was nothing they could do about it, few of the staff expressed enthusiasm or willingness to working with such patients.

One nurse, however, expressed a very different view: "Actually I'm not bothered by it, I am a nurse and I took a pledge you know, to relieve pain you know and all that stuff. So I'm ok working with it" (Nurse 2, nursing sister). This participant said she had no concerns about nursing patients with HIV/AIDS, and another nurse also expressed a strong commitment to the duty to care:

If nurses stop this kind of work, who would take care of these people? Also know that nurses are already leaving, it is our duty to stay to tell them to remain here. And what would happen now to the ill people? They are within their rights to be treated (Nurse 3, nursing sister).

Although this participant also regarded HIV/AIDS patients as an added burden on the ward, she felt a strong sense of duty towards providing care, as well as an awareness of the rights of patients to be treated.

Overall, most participants commented that they had no choice about having HIV/AIDS patients on the ward, and therefore how they felt about it did not matter. Their suggestions about a separate ward, however, suggest that if given the choice, many of them would not be prepared to work with HIV/AIDS patients. The literature indicates that an unwillingness to work with HIV/AIDS patients is often accompanied by the belief that such patients are not as deserving of care as HIV- patients and this could lead to discriminatory care. Three of the participants, however, expressed a commitment to the duty to care for all patients and a willingness to care for HIV/AIDS patients on the ward. It may be important, however, to note that these participants were nursing sisters, who have less contact with patients and are not involved in their physical care.

4.4. Emotional care of HIV/AIDS patients

The emotional trauma experienced by HIV/AIDS patients and their families has been identified as one of the main stressors of HIV/AIDS care among health care workers (Miller, 2000). Patients with HIV/AIDS often require intensive physical and emotional care and this has led to an expansion of the nursing role and the expectation that nurses will address and contain patients' emotional needs and those of their families. In the field of psychiatry, similar expectations are placed on nursing staff and yet the exposure to patients' emotional distress has been identified as one of main stressors in psychiatric nursing care (Kilfedder et al., 2001). The participants were therefore asked whether they were aware of the difficulties that patients experienced around their diagnosis, whether they spoke to patients about their illness and how patients' anxieties were addressed.

Nursing sisters in the study expressed an awareness of HIV/AIDS patients' need for support and acceptance in order to cope with their illness. They also said that they had little contact with families, as many patients whose condition deteriorated were not visited. As one sister said:

I always feel most concerned because... you watch how the patient comes in, and how often they come in and out of hospital, in and out, in and out, and then you also look at the conduct, how often do the family come and see the patient, you see? I do feel that most of them are rejected, by the families themselves. Maybe the family also cannot handle it
(Nurse 3, nursing sister).

This nurse expressed her concern at the lack of support shown by the family and friends of HIV/AIDS patients and concludes that many patients are rejected because of their HIV+ status. She also mentioned that stigma associated with mental illness was compounded by the stigma of

HIV/AIDS and thus made many families reluctant to visit the patients in the ward. These comments indicate to some extent the social fears and anxieties surrounding both mental illness and HIV/AIDS and raise questions about how this could impact on the institution and the staff caring for these patients. Another nursing sister also mentioned the issue of stigma:

Stigma is the one that kills anyone in this dilemma, should I tell people, should I not tell them? How are they going to accept me or they going to reject me and all this. So, it's psychological I mean Thabo or no Thabo even if he gives tons of medication. You won't get well unless your psychological part is treated (Nurse 4, nursing sister).

This comment indicates the sister's awareness of the dilemma that patients face around disclosing their HIV status in the light of the stigma around HIV/AIDS. She mentions that even medication to combat AIDS will not be effective in helping patients if they are not supported and understood during their illness.

Few of the staff, however, mentioned the emotional suffering that HIV/AIDS patients experienced around their diagnosis. Although there was some awareness that patients needed emotional or psychological support around their illness, the staff's perception of their own role, and the hospital's role, in providing support and guidance for patients seemed unclear. Nurses expressed a reluctance to engage with these aspects of patient care. Where nurses had become more personally involved in supporting HIV/AIDS patients, they found the patient's inevitable deterioration difficult to deal with. One such situation was described by a nursing sister:

There was this patient F, and we... we always got on well. Then she told me she was diagnosed positive and I couldn't believe it... I tried to support her and I told her everything about not thinking about having babies and all that, but when she came this time she was pregnant. So I was very concerned about her, and she has insight into her condition, but when she has to put things into practice then she doesn't do that. She has deteriorated a lot this time (Nurse 4, nursing sister).

The nurse quoted in this extract was disappointed and frustrated by her failed attempts to advise a mentally ill patient not to get pregnant because she was also HIV+. The patient's physical deterioration and her disturbed mental state on her recent admission were distressing for the participant. The literature suggests that in caring for those suffering from mental or physical illness, the feelings of responsibility towards patients can stir up anxieties and severe guilt in nursing staff (Hinshelwood and Skogstad, 2000). The anxieties evoked in the care of mentally ill patients are likely to be exacerbated by the added complication of HIV/AIDS and its resulting physical decline

and eventual death. The nurse also appeared to identify with the patient and this has been identified as one of the main stressors in HIV/AIDS care (Miller, 2000; Bennet et al., 1996).

The same participant, however, gave another example of talking to patients which did make her feel better:

The patients from C23, when they come here they come already with HIV positive [diagnosis], they are not so sick as they were when they were freshly admitted, so at least when they come in here we are able to talk to them and all that. I do feel good about that. I feel I've done something, because sometimes they can be very hopeless. I need to tell them that it's not the end of the world (Nurse 4, nursing sister).

This extract was one of the few comments made by staff about supporting AIDS/HIV patients. The comment indicates that talking to the patients allows the participant to feel a sense of achievement, of having helped in some way. However, it also reflects the nurse's need to reassure the patient, perhaps because acknowledging the pain and difficulty of the patient's experience is too overwhelming.

Other nurses felt that patients had no insight into their situation and that there was little point in talking about it. There was a sense in the interviews that because of their mental illness, patients were regarded as having no insight and that their feeling could not be accessed. As one participant commented:

Sometimes they don't talk to the nursing staff they just talk with the other patients. It's [the fact that the patient is HIV+] like a joke that moment for that one. And to us, we just watching her, then you think, she's got no insight she's just saying it because she doesn't really know what it means (Nurse 6, senior nurse).

This particular comment represents most of the staff's attitudes towards patients on the ward, regardless of their HIV status. Depersonalising patients in this way can be seen as a defence against the anxieties of working with people who are mentally ill and being contaminated by their feelings of chaos and pain (Hinshelwood and Skogstad, 2000).

Informing family members and providing support and information to the patient were also seen by respondents as the responsibility of the doctors, although none of the nursing staff knew whether this was actually happening. As one nurse said: "I don't know if the doctors interview them... but here is not a special programme that I know of. They need to go to a special session" (Nurse 6,

senior nurse). The diagnosis of HIV also raises complicated ethical dilemmas for the nurses who need to accommodate this in their work. This is reflected in the following comment:

The doctors, they don't help the family, they make it the responsibility of the patient to tell the family while she's at home or once she's recovered. I've never seen a situation where there's a family session, where the family is being told about a patient's HIV positive status. Sometimes the family do come to us, then you are in this dilemma whether to tell them because they normally want to find out about the prognosis, why is she not getting better, then you don't want to say because she's HIV positive she's never going to get better. With the other illnesses they can sometimes learn from you, but with HIV we tell them to speak to the doctor about the diagnosis. So it's just shifting everything away from me (Nurse 4, nursing sister).

Miller (2000) found that dealing with the family and friends of HIV/AIDS patients was considered by both doctors and nurses to be a major stressor in AIDS care. The nursing sister quoted above mentions that she does not explain the patient's condition to their family, because of the issue of confidentiality. This may, however, be complicated by her anxiety about delivering the news to the family, or of having to explain a prognosis which is complicated and uncertain. Therefore, referring the family to the doctor limits her contact with them and she seems almost relieved by the shift of responsibility. The extract also suggests the feelings of inadequacy that nurses may experience in HIV/AIDS care. In this example the nurses usual role of mediator between the hospital system and the family cannot be fulfilled and the role is transferred to the doctor, who has more authority in the medical hierarchy due to his/her medical knowledge of disease (Helman, 2000). The transfer of responsibility to those higher up in the medical hierarchy of the hospital system, has also been identified by Menzies Lyth (1960) as a defence to reduce the heavy burden of the responsibility on the individual nurse.

Overall the material in the interviews suggests that although some nursing staff recognise the patient's need for support, they are not certain whether this takes place and are mostly reluctant to engage with patients or their families about their illness. Despite the fact that this is a psychiatric ward, nursing staff do not appear to be involved in the emotional containment of patients and indeed, there appears to be a little empathy or concern for their emotional distress. Given the range of difficulties that they encounter in their daily work with such patients, it is possible that staff simply do not have the emotional capacity to engage with patients on issues regarding their diagnosis and how they feel about it. Ethical issues surrounding confidentiality may also complicate

matters for nursing staff. It would appear that to some extent nurses have distanced themselves emotionally from these patients in order to defend against the possible emotional contagion and anxiety that may result if they become too involved or care too much about patients (Menzies Lyth, 1960). Although this seems to be a common attitude towards most patients, it is particularly apparent in the care of HIV/AIDS patients on the ward.

4.5. The ward context

The previous sections have covered the nature of the work with HIV/AIDS patients and the difficulties and anxieties this gives rise to in nursing staff. However, the ward environment has its own stressors which exacerbate those mentioned above. Thus issues such as overcrowding, lack of staff and strained relationships with doctors and management are also factors that are likely to add to the experience of being overwhelmed by the work.

4.5.1. The busy ward

All female patients being admitted to Bergveld Hospital, pass through ward 14. As the hospital serves a large area of the Western Cape, there are constant admissions, although the ward can officially only accommodate 15 patients. During the month and a half that the interviews took place on the ward, the ward patient population was at 15 for only three days. For the remaining time there were up to 22 patients in the ward. There is therefore a constant need for bed space and patients are stabilised as quickly as possible and are then transferred to other wards in the hospital. “We are always full. Busy admitting every day. It’s a very stressful ward, this ward” (Nurse 1, nursing assistant). This comment by one participant reflects the sense of a task never completed, of there being no respite from the constant admissions and the pressure to stabilise and refer patients to other wards.

With regard to the staff component a similar discrepancy exists. During the day, two nursing sisters and four nurses are assigned to the ward, but often only three or four staff are actually on duty. The night shift is managed by just three staff members, a sister and a nurse and a female security guard. The ward is therefore often overcrowded and understaffed and a number of the respondents commented on these difficulties with reference to HIV/AIDS patients. As one sister on night duty said:

It’s very difficult, and the conditions are even worse... we are working minimal staff you know, and also the hospital is not designed to, you know to help HIV’s or whatever you

see. Think of it now, during the night we are only two, a sister and a nurse. How do you handle that being only two? With minimal staff it's really disgusting because there's no way that you can, what you call it, you can escape whatever, [HIV infection] you know? (Nurse 3, nursing sister).

This particular respondent had recently been attacked by a patient while working the night shift. She sustained severe bruising and described how at the time of the attack she feared for her life. The lack of staff on the ward thus exacerbates the fear of possible HIV infection and adds to a general feeling of the ward being a threatening working environment.

A number of respondents also reported that the lack of staff and high numbers of patients made it difficult for them to take time off during the day. As one nurse said:

You don't get a lunchtime, sometimes you must just force yourself and go out, even if the sister skel and moan, because here you don't have lunch. Maybe in the morning ja, we sommer take our tea time, but from then, sometimes when you want to go to the bank you must ask the sister, then she will say, okay, but you know you will have to rush because you know you are needed in the ward, you can't leave the ward (Nurse 6, senior nurse).

The response from this participant reflects a sense of feeling trapped in the ward with little opportunity to leave during a shift. This suggests that some staff feel that they have little time for themselves and no respite from the constant pressure and demands of the ward environment. The comment is in direct contrast to those made by two nursing sisters who reported that they managed to cope with the ward stress by leaving the ward during their lunch hour and that they insisted on taking time out.

Overall, staff said that they found the constant admissions and the lack of staff stressful and demanding. The low ratio of staff to patients was also felt to create an unsafe environment in a ward with aggressive HIV/AIDS patients. The ward atmosphere is one of constant activity, with time being used up by administrative tasks and the daily care of patients such as administering medication and supervising meal times and bathing. There is very little time for staff to interact with patients themselves outside of these activities. The busyness may represent a legitimate response to high work demands but might also, as Sinanoglou (1987) suggests, be a tendency of psychiatric staff to defend against the anxieties about becoming as lethargic and lifeless as some of the chronic patients on medication, by being involved in perpetual activity.

4.5.2. The role of the doctor

Difficulties in relationships with colleagues and other mental health professionals on a team are seen as central to the experience of occupational stress (Miller, 2000). Power issues can also result in the experience of stress, particularly for nurses, whose lower place in the medical professional hierarchy may leave them trapped in positions where they have insufficient authority to make decisions regarding their working environment and the patients in their care (Bennet et al., 1996; Miller 2000). In an attempt to explore these dynamics, participants were asked about their working relationships with the doctors on the ward. Two respondents said they had a good working relationship with doctors on the ward, and three declined to comment, but the rest felt that doctors did not consult them or communicate sufficiently with them and they blamed doctors for admitting patients and exceeding the ward capacity, regardless of the consequences for the nursing staff.

We are 15 [patients]now, we were 22 a few weeks ago, and these doctors work on your nerves because they don't send the patients back, like other hospitals when they are full.

Here ... they just take things, scrap, anyone (Nurse 6, senior nurse).

Doctors are often placed in difficult situations where they are pressured into admitting patients that fall into the Bergveld drainage area as other institutions are full. This impacts directly on the nursing staff who are already dealing with an overly-full ward. This comment from a participant reflects a sentiment voiced by a number of participants, namely that doctors fail to consider the impact of another admission on the nursing staff. In her response the nurse expresses anger towards the doctors on the ward, as well as to the patients or what she calls "scrap" being admitted.

A general perception held by a number of participants, was that doctors are often absent from the ward and therefore do not have a good understanding of the pressures that nursing staff have to contend with. One participant explained:

If doctors could come and see what we are doing, and what is happening then I'm sure it would not be so easy for a doctor to push the numbers. They are often not here, and I don't know whether I'm like making [it] up, but I also pick up a lot of stress, from the doctors especially doctors that are like responsible for admission, you know that day. You will phone around the whole hospital trying to get who is on call and meantime you have scores and scores of telephone calls coming through and the sister has to be called to answer (Nurse 7, nursing sister).

While nurses stay on one ward during their shift, doctors on ward 14 are also responsible for patients in the two other wards in the Women's Mental Health Unit and are required to be on ward 14 primarily for admissions and ward rounds. Their absence also means that some staff feel an added responsibility for coping with difficult situations and do not feel supported by the doctors in their work. This nursing sister's tentative comments about doctors being absent also seems to reflect an awareness of the stress they may be experiencing. Ultimately, the lack of resources and work pressure experienced by nurses are also likely to be experienced to some extent by other professionals at Bergveld hospital.

There was an apparent reluctance amongst participants to comment on doctors and their perceptions of them, however their absence from the ward and tendency to admit patients after the ward capacity had been reached were mentioned. In general there appeared to be an uneasy tension between nurses and doctors on the ward.

4.5.3. The role of management

The ward supervisors and administrators who oversee the wards at Bergveld are part of the hospital administration team and have offices in a separate building. The following were responses to questions by the interviewer about what support nurses received from management and whether they felt they could talk to their supervisors if they were having difficulties. For participants, the word "support" had different meanings. For some it meant someone to consult in a crisis, while for others it implied acknowledgement of their work, awareness of their difficulties and someone to talk to after the crisis.

Of the four nursing sisters interviewed two expressed the concern that the supervisors had very little idea of what was actually happening in the ward and were primarily interested in checking on administrative details. This is reflected in the following comment by a nursing sister:

Most of the time... somebody will come and only look at the wrong things you see? And automatically if you are only two [on duty] then you can't escape mistakes, there will be a few mistakes... but you find that at times they are only looking at why was this [not done], not how much did you do, you know? And you did it to your utmost best, because if one can follow the whole day in an admission ward... today they admitted six patients, besides your routine work, you see? And it's really depressing. Because at times you find that ok, I'm ok, I'm doing this for the sake of the patients, it's ok. But the minute like my official

comes in and then says what about this and this - then you are feeling fedup now. So most of the time it's not even the patients that make you depressed (Nurse 3, nursing sister).

This response from a nursing sister indicates that she feels her efforts are not appreciated and that interactions with management are primarily about what she failed to do, rather than an acknowledgement of what she did manage. Thus, despite doing her best on a busy day, her perception is that her work is not considered good enough by management. For this participant, the lack of acknowledgement and appreciation of her hard work are more discouraging than the difficulties of the work itself. This extract correlates strongly with points made in the study by Bennet et al. (1996), which showed that nurses who feel unrewarded and unacknowledged in their work are vulnerable to burnout, and further, that the adherence to organisationally-imposed criteria for achievement in caring for patients, can lead to nurses feeling that they are failing in their primary task. It is also possible that the experience of being stressed makes it difficult for staff to feel supported and also increases their sensitivity to perceived criticism.

Another nursing sister expressed similar concerns about management's awareness of the difficulties on the ward:

I would also like more transparency to whoever is involved in the sector, knowing what we are doing inside so that they can have a picture of what is happening, so that our care should become better. Because if there is no team spirit, you can forget about making it better (Nurse 7, nursing sister).

This particular comment suggests that management are perceived as having little understanding or awareness of the daily difficulties on the ward and that nurses feel isolated in their work on ward 14. The participant's comment suggests an awareness of the need for improved patient care, as well as an inability to do so if the current difficulties on the ward are not recognised and addressed by the staff as a team. There is therefore a suggestion in the comment that better support and an understanding of the stressors on the part of the supervisors is ultimately linked to better nursing care for the patients.

The two remaining nursing sisters in the study said that they felt that management was supportive and elaborated by saying that they were available in a crisis.

Sometimes something happens now and you want to talk now. Now I'll talk to the nurse here or maybe I'll phone my supervisor if it's related to admissions or patients who are

disrupting the ward and all that you know? Or for that matter the superintendent or Doctor S. or anybody and just confront them about the situation (Nurse 4, nursing sister).

In this passage, the nursing sister's response suggests that she adopts a proactive approach and actively seeks out help or 'support' when she requires it. While this may be effective in a situation where others in authority are needed to make decisions about patient care, it is unlikely that staff would use this method to receive support of a more emotionally containing nature.

Of the nurses in the group of senior nurses and nursing assistants, two felt that they could talk to their supervisors, but that this was not really necessary for them. The other three said they did not talk to their supervisors. As one respondent said. "Nobody, no. Maybe you can talk to the others [nurses], otherwise there's no-one we talk to" (Nurse 1, nursing assistant). This was a direct response to a question about who the participant felt she could talk to when the work became difficult. The literature emphasises the importance for nurses to have the space to explore and speak about the painful nature of their work in order to mobilise appropriate defences to protect themselves and continue with their work (Dartington, 1994). It became clear in the interviews that most participants believed that this space was not provided by ward supervisors.

Another nurse commented on the lack of guidance and support in her work:

You do your work and the next person does their work, but there's not really anyone who looks to see that we're doing things right, except maybe the sisters, but they aren't always there. There used to always be a sister on duty, but these days you take care of yourself. There are too few nurses and there aren't enough people to supervise us (Nurse 9, senior nurse).

This comment reflects not only a perceived absence of supervisors, but also a lack of guidance and support on the ward itself. Senior nurses and nursing assistants are trained through the hospital and therefore have less medical knowledge than the nursing sisters to whom they report. The tone of the comment suggests that the absence of available support and supervision from the nursing sisters on the ward has left this participant feeling isolated in her work. When asked why she felt unable to talk to her supervisor, the same participant replied with the following comment:

The management, the supervisors, they only come to the ward if there is a specific problem that they have been informed about, otherwise they don't come here. They don't know what we have to go through every day. It causes a lot of stress, those little problems between colleagues that don't get addressed. Because in any place where, if you have no

where to go to, if there is no one to help you and no one to talk to, then problems will come up (Nurse 9, senior nurse).

This comment was one of the few in the interviews that suggested interpersonal difficulties between nursing staff. The participant's comments also indicate again the perception that management are not aware of the difficulties experienced on the ward, as well as the understanding that problems arise when these difficulties are not recognised and spoken about. As in her previous comment, a sense of isolation and abandonment are apparent. The literature indicates that supervisor support has been identified as a critical buffer against work stress (Miller, 2000) and the perceived lack of support by supervisors on ward 14 raises important questions pertaining to the staff's ability to cope with the multiple stressors associated with their patient care.

Besides their apparent unavailability, issues of confidentiality were also mentioned by one participant as a reason for not approaching supervisors for support.

Oooh, you can't go to them [nursing supervisors], because they can gossip a lot, you can't do this. I tried to keep it confidential, but the next minute the whole hospital knows, so you just keep it for yourself, till one day you burst (Nurse 6, senior nurse).

This particular response reflects a lack of trust in the ability of supervisors to maintain confidentiality in relation to personal, confidential problems experienced by nursing staff. Again the lack of space to talk about difficulties is highlighted and it may also be particularly difficult for nurses to talk about the sensitive issues surrounding HIV/AIDS.

Nurses in the general nursing group also mentioned that supervisors had not been supportive after upsetting events. One participant mentioned the lack of response from management after the incident where a patient threw the water-soaked, used sanitary pad at her and other nurses.

They didn't do anything. Most of the other nurses, when they heard this story they were upset because they said, it was the sister's duty to call sister D. or anyone to come in and interview us or send us to Groote Schuur for a check-up or whatever, but at least they were supposed to be there for us, because everybody is scared of AIDS, and as you heard, AIDS is from this, and this, and this, but still your mind tells you no that can also give me AIDS. So nobody didn't do anything, nobody concerned, and now I must just go on with this... and it was the blood was in my eyes all over and I thought let me just wash it off with soap... what can I do, nobody else take notice. I just tried to forget about it, because what must I do? (nurse 6, senior nurse).

The quote indicates her tremendous anxiety regarding possible contagion, as well as her urgent need for containment and support from management around this time. The sense of helplessness and feeling of abandonment apparent in her comment indicate that her need for even a basic level of containment were not met. The result is that she had to try to forget about the incident and the distress associated with it, as there was no acknowledgement of her pain.

From the extracts quoted above, a theme emerges repeatedly in the comments made by nursing staff: management are seen by more than half the staff as absent, unaware of daily difficulties related to HIV/AIDS care and of the stress on the ward generally, and are often perceived as primarily critical in terms of feedback. Nursing staff feel that they cannot talk to management and there is a consistent theme of feeling isolated and unheard in their distress.

4.6. The emotional consequences of psychiatric HIV/AIDS care

4.6.1. Coping with distress and anxiety

In the course of the interview, all participants at some stage mentioned difficulties surrounding the care of HIV/AIDS patients and most mentioned incidents which had left them feeling anxious and distressed. As there appeared to be little support from the hospital, participants were asked how they coped after a difficult incident on the ward. All nurses reported that they talked amongst each other about upsetting incidents. Two of the nursing sisters on the ward also expressed concern about the nurses under their supervision and felt responsible for their emotional well-being. As one nursing sister said:

It's not like [talking to] a professional, but we talk. Like every morning I have to listen to people's aches and pains and whatever, even security [guard] you know, but I find that very comforting to me at least they are opening up they are saying something to me, but in response you know I don't feel I am of help to them. Now what I would normally say to that person, 'Are you ok?' and they say 'today I don't want to work' [and I say] 'No it's fine it's ok, as long as you are here with us' (Nurse 7, nursing sister).

The literature indicates that colleague support can help to reduce the stress associated with the workplace (Miller, 2000). For the sister quoted in this extract, there is comfort in providing her staff with a space to talk and actively showing an interest in their well-being. She feels responsible for her staff, at the same time, she doubts whether she is helping them. She appears to give permission for the staff to have days where they are not expected to perform at their best, as long as they make the effort to come to work. Another sister commented on a similar feeling of

responsibility towards nursing staff: “ Being actually the lady in charge, you must sort of take the nurses as your children sort of be like a hen over them. You must try to protect them, forgetting about yourself ” (Nurse 2, nursing sister). Again, a strong sense of responsibility is felt by this nursing sister, and at the same time, her own concerns are dismissed or ‘forgotten’. Later in the interview, the same participant expressed a similar view that she needed to be ‘strong’ for others when she mentioned her response to people with HIV/AIDS in her community.

Other than talking to colleagues, most nurses reported that they tended to try and pull themselves together after upsetting incidents and expressed ambivalence about showing their feelings.

It’s only after days that, because you know I think I had a delayed reaction you know, it is not there and then I felt like crying but I thought, I can’t cry in front of these patients, (laughs) because they will all think that they must now all take chances... No, no, I must be strong, as if nothing happened you know, you know and I was feeling... [it was] so close you know, she nearly killed me, I had to cry and she meant to kill me (Nurse 3 , nursing sister).

This participant was relating her reaction to an incident where she was violently attacked by a patient. Her initial resolve not to show her vulnerability to the other patients, and to simply deny her distress, crumbled as the reality of the event eventually struck home. The professional or “strong” nursing sister is seen as not showing her distress to the patients, who are also seen as likely to take advantage of her vulnerability. Her comments suggest that she seemed ashamed of her need to cry. The expectation to be seen as professional and thus, unemotional, reflects Menzies Lyth’s (1960) perception that professional detachment among nursing staff is reinforced when staff are discouraged from showing their emotions. In the following quote another nurse expresses her reluctance to show feelings, together with an inability to completely control those emotions in times of stress:

At the moment I am very stressful, I’ve got my own problems at home, and sometimes I can’t take it you know, I must say to myself just pull yourself together, and let the day pass, tomorrow is another day, and sometimes I feel cross and I show it on my face because I can’t keep it in (Nurse 6, senior nurse).

A sense of shame seems present in the comments of participants who admitted to being overwhelmed by their feelings. The literature suggests that in psychiatric nursing, the fragmentation and confusion experienced by patients may lead nurses to experience anxieties about their ability to prevent their own fragmentation (Sinanoglou, 1987). A reluctance to express

vulnerability or distress may therefore be connected to the investment in the role of a sane nurse versus a 'mad' patient.

Most participants mentioned that they tended to cope by cutting themselves off from the experiences of their day, perhaps because no other options are available.

What can you do? No, I don't want to think about it after work, I cut off when I walk out the door. If you take your stress home you start shouting and you're tired. No, I just keep myself busy when I get home (Nurse 8, nursing assistant).

Despite 'cutting off', there seems to be a danger of the work stress intruding on home life, thus the tendency to keep busy in order to avoid thinking or feeling about the day's work. A similar method of coping is mentioned by the following participant, although a supportive spouse is seen as helpful. "You take it home with you... I usually cut myself off because I have to pay attention to things at home. Sometimes, I talk to my husband and that helps" (Nurse 9, senior nurse). Another participant mentioned that she coped with her work stress by maintaining strict physical and emotional boundaries. "I get in my car and I go out for lunch. I must for an hour, I must go out of this ward. If I'm on lunch I don't stay here. I don't take my work home... I just go home and switch off" (Nurse 4, nursing sister). Insisting on taking her lunchbreak away from the hospital can be seen as a necessary and appropriate defence, however, her reported ability to "switch off" suggests a level of professional detachment which makes little allowance for the experience of anxiety and distress which is likely to occur in a ward with up to 22 psychiatric patients, some of whom are suffering from HIV/AIDS.

Only one respondent said that she spoke to people outside of the workplace and also participated actively in the community in order to feel a sense of achievement:

How do I cope? I have a nursing friend who I talk to. I go to movies with my children, I've got my ten year old T, we go to movies and then to picnics and I get involved in my church. I also have a project whereby we empower women financially and we help one another in terms of bereavement. [I'm] very much, involved outside[in HIV work], very much involved outside. It's not happening here it's happening outside, I find myself more involved outside, there is a platform for me to continue you know, talking with people to make the situation better, but when I come to hospital I find it difficult, because they are no resources available... [here]we talk, but it's never implemented (Nurse 7, nursing sister).

For this nursing sister, taking time out with family and friends and being actively involved in her community seem to give her a sense of meaning and purpose. She seems to feel that her work does not allow her to make a difference and so satisfaction is gained from actively implementing her ideas outside of the workplace. The passage also indicates that despite nurses' perceptions that they carry most of the responsibility for patients on the ward, there is a sense in the interviews that they feel they have the least power to create change in the ward. Despite having the most contact with patients, nurses rank below other staff in the medical hierarchy and their actions are limited by their duties of carrying out doctors' orders and maintaining hospital routines (Samuelson, 1991). It is interesting to note that at the time of the interview this participant was making plans to leave the hospital as she felt she could no longer cope with the conditions on the ward or contribute in a meaningful way.

Overall, the nurses interviewed seemed to cope with their anxiety and work-related stress by trying to deny it and cutting themselves off from their work at the end of the day. Many felt a sense of shame when their emotions overwhelmed them and seemed invested in the image of appearing 'strong' and 'professional'. The possible consequences of this are discussed in the next section.

4.6.2. Response to stress in the workplace

The literature suggests that where nurses are not given the space and opportunity to talk about the difficulties in their work, in order for them to be acknowledged and understood, appropriate defences cannot be developed to protect themselves against the anxieties inherent in their work. If appropriate defences are blocked, the alternatives are either a tendency towards developing symptoms of burnout, and/or the development of pathological defences to protect them against the conscious experience of anxiety and uncertainty in their work (Dartington, 1994). Some of the defences against the protection of anxiety and their consequences (nursing staff feeling devalued and isolated) have already been mentioned, but some of the more obvious signs of occupational stress were also mentioned by participants towards the end of the interviews. Nurses were asked how they felt about working on the ward, given the difficulties they had mentioned. The following responses reflect a general sense of disillusionment about their work and indicate that nurses are also leaving nursing, taking days off and experiencing work-related emotional exhaustion. As one nurse said:

I liked this nursing and I came being really dedicated you know. From the very beginning, it was not like by mistake, because there was no other job for me... But now sometimes I say

when I'm angry, depressed about work 'ag, this nursing I don't even want to work' you know, but I always say that when I'm angry. When I'm depressed for work, I'd say that ag, I won't recommend it for a young person or a relative of mine, not this work (Nurse 3, nursing sister).

This participant expresses her original dedication to nursing work and how this has changed. She now finds herself feeling depressed and angry about her work and it became evident in the interview that this was linked to a sense that her work was extremely demanding and that her efforts were not acknowledged or appreciated by management.

Staff reported feeling burnt out and unhappy about working in this particular ward:

I've been here for a year. Sometimes then they just forget about you (laughs). They keep you here longer, I don't know why. For me, I'll stay, but sometimes it feels like it's too much, then I feel I just want out... I don't want to stay here any longer (Nurse 9, senior nurse)

This participant seems almost resigned to her extended duty on the ward, although she admits that she finds the work overwhelming. Another nurse also mentioned her extended time on the ward:

Sometimes you do feel miserable, you feel moody and if you go off sick, it's an issue. You can't stay out of work. It's a lot of pressure, and there's no one to listen to you. Because they just leave you in this ward because they think you can cope in this ward, they need you here for a year. All of us here at the moment in this ward don't feel like this, at the moment we are all stressed out, we are burnt out, we are tired, we are sick and tired of this ward, and we just want to be moved to another ward, but nobody is taking notice you know. At the moment I feel like just to sit in the house, like last week, I was saying I feel like just to sit in one corner, and see no one and don't even want to eat my food I just want to be alone (Nurse 6 senior nurse).

Her comment indicates that she feels overwhelmed and exhausted by the work in the ward and the only option for her is to be transferred to another ward. Three of the nine participants complained about being 'stuck' on the ward for longer than the three months which is the standard time between ward transfers. Ward 14 was seen as a stressful ward by participants and some felt that they had been forgotten there by the hospital administration. This nurse mentions the stress of the ward, the lack of support and a tendency to stay away from work which is frowned on by management. Exhaustion and headaches were some of the work-related symptoms of stress that nurses gave as reasons for their absenteeism:

I got a lot of headaches last year, we get sick from the stress. Every now and then we take an extra day off for ourselves, but we discuss it amongst each other. I'll feel like I'm going to take tomorrow off because I had a difficult day today, I just feel that I want a day to be quiet and forget (Nurse 9, senior nurse)

When asked about the reason for staff absenteeism, one nursing sister gave this response:

There's registration of the children because the schools have re-opened, people are burnt out and it's the same people that work in the same ward. Other people refuse to rotate... and our policies are also, you know like affecting the situation. Because if you are like not consistent with policy, ja, then you find this kind of management (Nurse 7 nursing sister).

This nursing sister mentioned that staff were registering their children at school (more than half of the participants in this study are single parents) and were also burnt out. Apparently the rule of circulating nurses amongst the wards is not always enforced and some staff refuse to work in ward 14. This means that some nurses spend up to a year in the ward. The sister went on to say that the lack of support from the hospital and the understaffing in the ward is resulting in nurses leaving the hospital and that she is also making plans to leave. She gave her reasons as the following:

There is actually no support from the hospital because there is no staff, and staff are slowly leaving the country, like every month staff members are leaving the hospital... I may not stay here. I've applied elsewhere, people are leaving. I feel I could be better used somewhere else (Nurse 7 nursing sister).

Overall, staff reported psychosomatic symptoms, taking days off and feelings of depression, all of which have been identified as emotional and behavioural symptoms of chronic occupational stress (Miller, 2000). A number of staff have already left the hospital and two of the nurses interviewed for this study had left by the time the last interview had been conducted. Currently more than 300 specialist nurses leave South Africa every month according to the Democratic Nursing Organisation of South Africa, and many of these have given poor working conditions as reasons for their leaving (United Nations Integrated Regional Information Network, 2002).

4.7. HIV/AIDS related anxieties in the personal lives of participants

Approximately four million South Africans are currently HIV+, although recent figures are estimating that the actual number is closer to five million, that is 1/8 of our population. All sexually-active adults are at risk of infection and advertisements and billboards around the country

act as constant reminders to the public to practice safe sex and get tested in order to know their HIV status. Furthermore, the epidemic is moving from the 'invisible' (HIV+) to the 'visible' AIDS stage with an increasing number of people dying in hospitals and in communities. HIV/AIDS is therefore a reality for all South Africans and it no less so for the nursing staff who participated in this study. Besides being confronted with the reality of HIV/AIDS through their work with patients, participants also commented on the impact of the disease in their lives generally and how their work with patients was perceived by others. The following section takes a look at the impact of HIV/AIDS, and HIV/AIDS caregiving, on participants' personal lives in their homes and their communities.

4.7.1. The risk of infection outside the workplace

Issues around their own sexual behaviour and the risk of infection were mentioned by three of the participants. They reported an increased awareness of their own vulnerability to the disease because of the number of HIV/AIDS patients on the ward. One concern raised by a participant, was the issue of contracting HIV through an unfaithful spouse.

That morning we came on duty and we were sitting around the table drinking tea, talking about AIDS, that was just something that come up, every morning we've got something different to talk about. That morning the sister was saying in a joke now, this week it's her AIDS free week, she's not going to sleep with her boyfriend because he didn't come home. We were laughing and she was saying in a few years all of us will have AIDS (Nurse 6 senior nurse)

Although the discussion is treated in an almost light-hearted manner, there is a concern about the very real risk of infection and this is highlighted by a comment made by the same respondent at a later stage.

Sometimes I'm thinking, because my husband is working away, he comes home every third month, so maybe I need to be tested, but I am scared in a way. I will go but I don't want to hear my results (Nurse 6 senior nurse).

This comment indicates that concerns about HIV/AIDS are close to home and not just related to their working environment. A number of nursing staff when asked about whether they would consider going for HIV testing, said that they would prefer not to know their HIV status.

A comment made by another participant indicates that identifying with patients makes the issue of HIV/AIDS difficult to ignore. Her awareness of HIV/AIDS highlights the nurses own vulnerability to contracting the disease through sexual contact.

Sometimes you see someone will look like you, who is completely like you and there is nothing, then you test this person and then the test is HIV positive, then it starts coming to your mind and then you think that you might also be. All the little symptoms that you have then you worry about it, because the more you get exposed with this thing the more you become aware. If you are not working with HIV positive people, sometimes you tend to forget you know, but now you worry about those little things that you had, you got the flu or anything then you worry, and you become very stressed (Nurse 4, nursing sister).

These extracts highlight the increasing awareness amongst nurses about their own sexual behaviour and their risk of infection. Identifying with HIV/AIDS patients has been found to be more stressful in cases where nurses also identified themselves as being at risk of possible HIV infection (Miller, 2000). Thus, workers who consider themselves at risk, are constantly reminded of their own possible death and their own vulnerability through their work with HIV/AIDS patients. The role expansion that has occurred in nursing as a result of the complex nature of HIV/AIDS care, also includes the need for staff to accept sexuality as a professional focus in order to educate and advise patients. This has been identified as a stressor for HCW, especially if they are not taking the necessary precautions in their own lives.

4.7.2. Responding to HIV/AIDS in the community

During the interviews it became apparent that two of the participants continued to provide a service linked to HIV/AIDS outside of the workplace in their home communities. These participants were both black nursing sisters who were often approached by neighbours and community members for advice or support because they were known to be nurses working with HIV/AIDS patients. Both participants said that their work continued after working hours and that they felt they had a responsibility to respond to the needs of people in their communities. As one sister said:

One of my cousins she's just been diagnosed with HIV, you know it's still going through us, yes and it's quite sad. I've been seeing it, I know it's happening right here, but I've been seeing like the other side of the window but now it's here. I have to be strong and the

sole person who supports everybody, like when she revealed her status I had to be called. A lot of people come to me in the community (Nurse 7, nursing sister).

For this participant the reality of HIV/AIDS has moved from the realm of professional experience to the direct experience of the suffering of one of her family members. Family members and community members confide in her and she appears to carry the overwhelming responsibility of supporting people in her home environment. Although this extension of her professional role may be seen as an added burden for this participant, she expressed relief at her ability to provide a service outside of the workplace. As mentioned in the previous section, this participant is actively involved in HIV/AIDS support groups in her community and feels more effective in these activities than she does about her work in the hospital. The other sister made this comment about the emotional impact of helping to nurse very weak AIDS patients in her community:

You do feel like sad, for actually you know at the end then maybe they are going to die but as a nurse we must try to be more supportive not to show to your anxiety. Because the people are all looking up to you you understand, because they think that you know, you know everything but and then you must be closing yourself in a room and cry a little bit you know (Nurse 2, nursing sister).

For this participant her role as a nursing sister is seen as one of support and professionalism which extends to her life outside the hospital. There appears to be little space for the participant to share her own distress, either at work or in her social environment. Her crying is done in private and she mentioned later in the interview that she does, at times, feel resentful of the demands made on her by community members.

For both of these participants the boundaries between their personal lives and their work have been crossed because of HIV/AIDS. The disease has become a more personal experience, affecting family members and friends and placing both participants in positions where they feel a professional responsibility to provide support and care. The personal stressors in their home environment thus echo those experienced in the workplace and may well lead to further stress and confusion around personal and professional roles (Gibson & Swartz, 2001).

4.7.3 Family and community responses to HIV/AIDS and mental illness

In order to explore whether participants' families were supportive and accepting of their work in ward 14, they were asked whether their families knew about their work with HIV/AIDS patients. The literature indicates that social support may provide a protective effect against burnout, by

giving nursing staff an opportunity to express their feelings, thereby minimising any sense of isolation and creating a forum for passing on coping strategies (Kilfedder et al. 2001). Participants' responses differed according to their rank (sister or nurse) and cultural group (black or coloured). The nursing sisters, all of whom are black, said that their families knew about their work, and two of them were called on to help HIV/AIDS sufferers in their communities. The nurses, however, who are all coloured said that they tended not to talk to friends or family members unless they were also nurses. In the nursing group, all but one participant said that they didn't know of people, other than the patients, who had HIV/AIDS. As one nurse said:

No, I don't know of any people who have AIDS, it's just here at work that the one male nurse had AIDS and he left. People will keep it a secret if they know they have it. They won't talk and where I live people are very nasty, I mean even if they hear gossip about you they'll make a big issue of it, they'll even laugh at your children. So people don't talk about it (Nurse 9, senior nurse).

This nurse explains her reason for not knowing any people with HIV/AIDS in her community, namely that people keep their HIV status a secret because they fear the prejudice, and possible ridicule, of those around them.

Negative reactions from family members towards HIV/AIDS care workers have been identified as a serious stressor. Miller (2000) uses the concept of social contagion to describe the way in which the threat of HIV infection and the association of HIV/AIDS with marginalised and stigmatised social groups, determines the way in which health care staff are seen by those around them. The concept of social contagion can be seen in the next quote where the nurse fears that her children would disapprove of her work with HIV/AIDS patients and her close physical contact to them.

I don't talk to them [family] about it. I don't tell them about this AIDS situation, I don't talk to them. If I must talk to my children, they will say but mummy, how can you work in a ward like that, or why don't the people do something or, you know? And then afterwards, I don't know how they will feel inside, maybe they won't tell me but they will think, our mummy comes home every night with that top you know, and its dirty (Nurse 6, senior nurse).

The response from this participant suggests that she does not tell her family about her work in order to prevent a barrage of questions and their possible fear of social contagion. A similar view was expressed by the following participant. "I don't tell them. They'll be worried that I can also

get infected” (Nurse 1, nursing assistant). Here, the fear of infection, no matter how irrational, is associated with working with HIV/AIDS patients.

Both groups of nurses mentioned the stigma associated with mental illness and people’s fear and ridicule of “madness” and institutions such as Bergveld.

My family knows and they don’t have a problem with it [that I work with AIDS patients].

It’s more my friends... and then they don’t worry so much about AIDS, but more about the type of hospital I work at, it’s about that rather (Nurse 9 senior nurse).

This participant mentions the stigma surrounding mental health institutions. This experience was echoed by a black nursing sister, who felt that the public do not understand mental illness and are still afraid of those suffering from it. “Actually you do speak to your family... they always ask how do you cope with it? They are scared, I think the public are still not aware of our patients, they are scared of them” (Nurse 2, nursing sister).

These comments from participants indicate the social stigma surrounding both HIV/AIDS and mental illness. Although nursing sisters are able to talk about their HIV/AIDS work and are even approached for help in their communities, the stigma around mental illness is still evident. For the coloured nurses both issues are a social taboo and there appears to be a sense of shame about their working environment and a need to protect their families from this. The fear of social contagion refers to the perception that nursing staff are negatively altered through their association with HIV/AIDS patients and this perception is suggested as a reason for why staff would prefer not to tell their families about their work. Ultimately these comments suggest that participants do not have the approval and support in their social environment that they need in order to feel valued in their work.

4.8. Recommendations for improvements

Participants were asked at the end of each interview what they needed to help them in their work with HIV/AIDS patients and what the hospital could do to assist them in this regard. Most respondents struggled to answer this question and one nurse even suggested that she needed a budget first. It appeared as if nursing staff were not used to being asked what they needed. After much encouragement, three nurses requested assurance of treatment in case they were infected with the virus at work or suggested some sort of danger pay so that they would be able to take care of themselves if they did become ill. There were also requests for further information about

HIV/AIDS issues, and support in dealing with their own families and the threat of HIV/AIDS to the staff's teenage children. As one nursing sister said:

At the moment we actually need more empowerment and knowledge. The staff also need to be supported, because I mean as parents we also have daughters who are 18 years and we have cousins who are confronted with this [HIV] diagnosis (Nurse 7, nursing sister).

The request for support around HIV/AIDS issues close to home is an important consideration, as exposure to HIV/AIDS and the emotional and physical suffering associated with the disease, is not limited to participants' working environment.

There were a number of requests for support on the ward, both in terms of emotional issues, as well as information and guidance around HIV/AIDS issues with patients. As one nurse said:

They can just give support to us. You know, they could ask somebody to come and educate us more about HIV/AIDS and all that, and give us support when we've got HIV patients and all that (Nurse 1, nursing assistant)

Others requested more direct contact from management and the doctors to increase their awareness of the difficulties on the ward. The need for support and a multi-disciplinary team approach to treatment were emphasised by a participant in the following comment:

What can I say... suggestions... support each other in the ward, we must work together as a team, not only the nurses, also with the doctor concerned, we need a good relationship with them (Nurse 2 nursing sister).

The interview material indicated that nursing staff are left feeling overwhelmed by the responsibilities of providing adequate care for HIV/AIDS patients and that they do not feel supported by other professionals on the ward.

Overall, more than half of the participants requested information, training and support in the area of HIV/AIDS. This is understandable as the interview material has shown that with so many demands on them, staff often feel a sense of professional inadequacy, a common phenomenon in the field of AIDS care (Miller, 2000).

CHAPTER FIVE: DISCUSSION

“Yet again disease becomes a metaphor, and AIDS... reminds us of our vulnerability, our humanity and our need for community” (Pastore, 1993)

In exploring participants' experiences of psychiatric HIV/AIDS care, the interview material suggests that nurses face enormous personal and professional challenges in their work. The difficulties experienced appear to be related not only to the nature of the work, but also to the context of their working environment, and to extend beyond this to the broader social influences of family and community life. Overall, nursing psychiatric patients with HIV/AIDS was experienced as difficult and stressful by participants, and evoked strong emotions of fear and anxiety. This chapter provides an overview of these difficulties, the associated anxieties, their management and their impact on participants.

The fear of contagion was mentioned by all participants and appeared to be central to most of the difficulties experienced by nursing staff in caring for HIV/AIDS patients. As this fear appears to concern either physical or social contamination, these aspects will be discussed separately. The fear of physical contagion was strongest in situations where patients were aggressive or restless because of their psychotic state; where patients with stage four AIDS required intensive physical nursing care; and where nurses were exposed to the body fluids and wastes products of patients who were either known, or thought, to be HIV+. The fear of HIV infection must also be understood within the ward context and the reality of the conditions on ward 14. As the ward is often understaffed and overcrowded, nurses may have legitimate concerns about their safety around aggressive HIV+ patients. The ward also lacks appropriate facilities for nursing physically ill patients with a contagious disease. The lack of resources such as suitable gloves may also compromise adherence to infection control guidelines, and thus put nurses at risk of infection in the physical care of AIDS patients. Participants reported feeling frightened, threatened and unsafe in these situations, or retrospectively, when a patient's HIV+ diagnosis was established. Thus, patients who were initially thought to be 'innocent' were later regarded as a threat and patients who evoked pity and compassion, due to their severe physical illness, were also feared. These conflicting emotions appear to represent a central conflict in the care of HIV/AIDS patients, namely nurses' fears of contracting the HI virus versus their duty to care for patients. Participants seemed to defend against the anxiety of this conflict primarily through denying the presence of HIV/AIDS and the risk of infection. This can be seen in the remarks of some nursing sisters that they tend to 'forget'

about HIV/AIDS and the tendency of most nursing staff to refrain from wearing gloves, thereby exposing themselves to the risk of infection.

Participants' lack of adherence to precautionary measures suggest the possibility that their unacceptable feelings surrounding the fear of contagion are controlled by behaviour patterns which are directly opposed to them. Anthropological theories on risk-taking behaviour also stress the context in which such behaviour occurs and suggest that the perceived level of control over circumstances within that context will inform people's behaviour and perception of risk (Kielmann, 2000). Adverse working conditions may therefore lead nursing staff to actively dismiss the risk of infection in order to meet the demands of their work (McCann, 1998) and the stressful working environment and lack of resources on ward 14 may therefore further reinforce risk-taking behaviour. Whether viewed from a psychodynamic or an anthropological perspective, risk-taking behaviour appears to be motivated by a individual's need to reassert control when experiencing stress or fear. Within a working environment such behaviour can only be collectively adopted and maintained if sanctioned by the culture of the institution (Douglas, 1985). The literature indicates that although institutions provide guidelines for precautionary measures in order to reduce the risk of infection, these measures are often not implemented due to a lack of adequate resources and/or staffs' subjective perceptions of risk (Berkowitz & Nuttall, 1996). In ward 14 infection control guidelines were neither visibly displayed nor enforced by the nursing sisters and, despite the high prevalence of HIV+ patients on the ward, nurses were not provided with appropriate gloves of the right size. The tendency of health care institutions to downplay the risk of infection has been given as a reason for the ongoing fear of contagion amongst health care workers (Gerbert, 1988 as cited in Bellani et al., 1996) and the situation on ward 14 suggests that the hospital has not acknowledged the real risks that staff may be exposed to in their work.

The risk of physical infection was also mentioned with regard to other patients on the ward. These concerns were related to aggressive behaviour and fighting between patients, as well as the fact that patients may need to share toothbrushes and face-clothes. Participants reported feeling responsible for protecting other patients from infection and experienced strong feelings of guilt when patients were at risk. The responsibility of containing a contagious disease on an overcrowded, understaffed ward has resulted in some staff feeling overwhelmed by the responsibility and doubtful of their ability to provide quality care for their patients.

For some participants the fear of physical contagion appeared to go beyond the objective risks involved in contracting the HI virus through direct and immediate exposure to patients' body fluids. Some participants expressed concerns about using the same eating utensils and facilities as patients with HIV/AIDS, reported feeling 'dirty' because of their contact with them and expressed strong feelings of revulsion towards AIDS patients. These fears were expressed mainly by senior nurses and nursing assistants who have the most direct, intimate contact with patients and who have received their nursing training at the hospital. While these irrational fears may in part be related to a limited knowledge of the disease and viral transmission, they also suggest that on an unconscious level, nurses fear contamination from the stigma associated with HIV/AIDS. Anthropological theories of disease suggest that HIV/AIDS has become more than a clinical condition and can be seen to be symbolic of what is considered socially or morally wrong in modern society (Helman, 2000). As such, the fear and stigma associated with AIDS represents society's fear of harm, collapse and disintegration (Gilman, 1991) and nurses are not exempt from societal fears around HIV/AIDS. The nurses who expressed these fears live in communities where, as they reported, HIV/AIDS is a highly stigmatised illness and is not spoken about. It is therefore possible that for some participants unconscious fears around being infected by the stigmatised 'other' increased the anxiety associated with the care of HIV/AIDS patients. Nurses appeared to defend against these anxieties by depersonalising. It is also likely that patients with HIV/AIDS were aware of participants' fears and reluctance to nurse them and that this prompted their provocative or 'spiteful' behaviour, causing nurses further distress.

A further stressor reported by participants was the nursing of physically ill and dying AIDS patients. Nursing patients with incurable diseases is considered one of the most stressful tasks in nursing (Menzies Lyth, 1960) and HIV/AIDS care (Miller 2000) but it is also one which psychiatric nurses are not ordinarily exposed to. Furthermore, ward 14 is not equipped for physical nursing and the added responsibility left nurses feeling overwhelmed and resentful. Confrontation with death and dying is likely to evoke strong anxieties in nurses, as caring for such patients is likely to remind health care workers of their own vulnerability and their inability to prevent death in their patients and themselves (Speck, 1994). The helplessness experienced in the care of AIDS patients and the lack of available pharmacological treatment for such patients may well explain the sense of relief that some nurses reported after the AIDS-related death of a particular patient. For other participants, however, the patient's death was a shock and evoked strong feelings of grief. Ultimately, coping with death and physical illness in AIDS patients are new challenges for nurses in

psychiatry, and as yet little appears to have been done to address these new concerns and their impact on staff and patients.

Both the fear of contagion and confrontation with death and dying are considered to be major contributors to the experience of occupational stress in the field of HIV/AIDS care (Miller, 2000). Participants' experiences of nursing HIV/AIDS patients on ward 14 appear to confirm this, although it appears that these stressors are exacerbated by the aggressive behaviour of psychotic patients and the lack of facilities and resources in psychiatric wards. There is currently also no government policy which addresses issues around the treatment or containment of HIV/AIDS patients in state psychiatric hospitals. The South African governments' slow response to the HIV/AIDS crisis suggests a denial of the seriousness of the epidemic and has left psychiatric hospitals such as Bergveld without guidelines or strategies for addressing the consequences amongst their patients and their staff.

One stressful aspect of HIV/AIDS care which was mentioned repeatedly in the literature and which was, however, hardly mentioned by participants, was the stress associated with containing the emotional trauma experienced by HIV/AIDS patients and their families. While some nursing staff seemed aware that patients and their families needed support around the diagnosis and information about HIV/AIDS, they did not know if was being provided by other medical staff on the ward and did not see this as their responsibility. Other nurses showed little concern for HIV/AIDS patients' emotional state and participants displayed a general reluctance to engage in this aspect of patient care. This attitude seems particularly surprising in a psychiatric ward where nurses could be expected to be aware of patients' emotional distress and their need for containment and support. While the reluctance to engage with the emotional aspect of patient care appeared to be a common attitude towards most patients on the ward, it was particularly apparent in the care of HIV/AIDS patients. The possible reasons for this approach in the care of HIV/AIDS patients and the consequences for both nurses and patients need to be considered. In working with patients with mental illness, nurses are constantly exposed to patients' emotional chaos and pain; when patients are also aware of their HIV+ status, the fear of death and extreme feelings of helplessness and anxiety may also be present. Nurses may therefore distance themselves emotionally from such patients in order to defend against the possible emotional contagion and anxiety that may result if they become too involved or care too much about patients (Menzies Lyth, 1960). A number of these defensive strategies, as described by Menzies Lyth, seemed to be used by nursing staff and

were entrenched within the social system of the ward. These defences included a tendency to depersonalise patients, as can be seen by comments made by some participants that patients on the ward were too ill to know what was happening and that their perceived lack of insight meant that there was little point in communicating with them. The stressful nature of the ward and the constant activity of admissions also made it difficult for nurses to engage with patients outside of the routine activities of providing medication and daily physical care. Thus there was simply no time to talk to patients or establish supportive relationship with them. Another defence which became apparent in the interviews was the lack of clarity about who was responsible for patients' emotional care in the ward and a tendency to shift this responsibility upwards in the medical hierarchy. Menzies Lyth suggests that this provides staff with additional protection from the impact of responsibility and, given the overwhelming responsibilities that nurses already face in this particular ward, such a strategy may be the only available way of coping. The possible consequences, however, are likely to have a negative impact on both nurses and patients. By limiting the contact between nurses and patients, social defences in institutions also limit the amount of satisfaction and reward that such interactions can provide for nursing staff. The participants' focus on patients' physical care, and their emotional detachment, may also be perceived as cruel and uncaring by patients who are experiencing severe trauma and emotional pain.

There are also more practical considerations regarding the role of nurses in HIV/AIDS care which could have influenced participants and increased both their reluctance to engage with family members and their tendency to shift responsibility for this onto the doctors on the ward. HIV/AIDS has expanded the professional role of nursing (Mann, 1990; Miller, 2000) and has increased concerns within the nursing profession about professional inadequacy in nursing staff and requests for further training. Nursing staff in ward 14 have not received adequate training about HIV/AIDS and most participants had only a limited knowledge of the illness. While nurses on ward 14 often act as mediators between the hospital and families in terms of explaining the patients' diagnosis, this role is not apparent with HIV/AIDS patients. One nurse remarked that she did not know what to say to families about HIV+ patients' prognosis and this suggests that nurses may simply not feel knowledgeable enough about the disease. Without appropriate training nurses may also not feel comfortable to discuss sexual behaviour and safe sex practices with patients (Miller, 2000) and this, too, could impact on their willingness to provide even basic support or advice. Power relations in hospital hierarchies are established in accordance with knowledge

(Helman, 2000), with nurses having the least power and decision-making ability, while doctors are positioned highest in the hierarchy. Through their intimate contact with patients, nurses can, however have an important impact on patients' quality of life and play a powerful role in communicating the needs of patients to the medical doctor. In order to do this nurses need to be involved in decisions around patient care and to have information and training about the disease. In ward 14, where nurses have little knowledge about HIV/AIDS and are not involved in treatment decisions, it is possible that they may feel inadequate in terms of their knowledge and skills and may therefore actively distance themselves from HIV/AIDS patients. Empowering nurses through appropriate training is therefore likely to be important in increasing feelings of professional competence, reducing anxiety related to HIV/AIDS care and improving the care of patients.

The issues mentioned above highlight the difficult and anxiety-provoking nature of psychiatric HIV/AIDS care on ward 14 and the individual and collective ways in which this anxiety is managed. This may to some extent explain why participants mentioned few instances which indicated that caring for such patients was experienced as rewarding or positive. Although participants did not want to refuse care to HIV/AIDS patients, the majority of those in the group of senior and assistant nurses expressed a reluctance to work with HIV/AIDS patients, particularly in situations where their own safety could not be ensured. In the group of nursing sisters a similar reluctance was expressed but most of the participants in this group also expressed a commitment to providing care for HIV/AIDS patients and recognised their right to be treated. Overall, however, HIV/AIDS patients were seen as yet another burden in an already stressful ward. This suggests that stressors experienced by participants are not only related to the anxiety provoking nature of HIV/AIDS care but may also be related to the more general experience of the ward itself being a stressful place to work. The ward context and the level of support that staff receive in their work are therefore important in understanding the impact of HIV/AIDS care.

As has been mentioned, the number of patients in ward 14 often exceed the ward capacity of 15 with up to 22 patients on the ward. This places nurses under enormous pressure; their time is spent in performing administrative tasks and the daily care of patients such as administering medication and supervising meal times and bathing. Some participants expressed resentment towards the doctors on the ward for admitting patients without considering the implications for nursing staff and for also often being absent from the ward. Nursing management and the nursing supervisors were perceived by most participants as being primarily interested in the effective

administration of the ward and, although they could be called in to help in making practical decisions, staff could not approach them for emotional support. Overall, management were seen by more than half the staff as absent, unaware of the daily difficulties related to HIV/AIDS care and the stress of the ward generally, and were often perceived as primarily critical in terms of feedback. Most of the participants therefore felt that they could not talk to management and expressed views which indicated that they felt isolated and unheard in their distress and that their hard work was not acknowledged. The literature on stress in the nursing of HIV/AIDS patients has found that supervisor support is most significant in reducing the effects of occupational stress (Miller, 2000; Bennet et al., 1996). Having support in the workplace was significantly associated with nurses being empathic towards patients, rather than being detached and cynical about patients' needs. Supervisor support was also significantly related to nurses finding their work with HIV/AIDS patients rewarding, whereas those with no support were vulnerable to burnout and felt unrewarded and unrecognised in their work.

Most participants mentioned incidents with HIV/AIDS patients which left them feeling anxious and distressed, but the lack of support from supervisors indicated that these experiences could not be spoken about, addressed or contained. Participants therefore appeared to defend against these anxieties by denying their feelings, by being 'strong', by 'cutting off' their emotions and by investing in the idea of the unemotional, 'professional' nurse. This defence seemed to be collectively adopted by all participants to the extent where nurses expressed a sense of shame when they felt emotional or overwhelmed by their distress. As explained by Menzies Lyth (1960), social defence systems in nursing are established to help the individual avoid the conscious experience of anxiety, guilt and uncertainty. However, they inhibit the true mastery of anxiety and thus, over time, increase the experience of anxiety in the work. The consequences of this are often seen in the physical signs and behavioural symptoms of burnout and these were evident amongst participants in this study. Overall, staff reported psychosomatic symptoms, taking days off and feelings of depression, all of which have been identified as emotional and behavioural symptoms of chronic occupational stress (Miller, 2000). A number of staff have already left the hospital and two of the nurses interviewed for this study had left by the time the last interview had been conducted. This suggests that staff are physically and emotionally stretched to the limit and that urgent measures are required to provide them with effective support and containment.

The issue of support is also relevant when considering the broader social influences which nurses are exposed to in their families and communities. Depending on the visibility and disclosure of HIV/AIDS in their communities, participants were either secretive about their work with HIV/AIDS patients for fear of being judged, or were drawn into extending their professional role by providing support to family members and community members who suffered from HIV/AIDS. For most nursing staff their home environments therefore did not provide support nor, in some cases, acceptance of their work. The personal impact of HIV/AIDS on participants was also evident, not only with regard to family and friends being diagnosed HIV+, but also in terms of nurses' awareness about their own sexual behaviour and that of their spouses in terms of being at risk of infection. Identifying with HIV/AIDS patients in situations where nurses also identified themselves as being at risk of possible HIV infection, and the social stigma of working with this marginalised group, have both been identified as major stressors in the field of HIV/AIDS care (Miller, 2000).

There are therefore a range of factors which have resulted in the experience of stress for participants in this study. Lack of policy guidelines on the admission and containment of HIV/AIDS patients in psychiatric hospital, overcrowding, understaffing, a lack of facilities and resources have created a context within which nurses are expected to perform their duties. Added to this is participants' limited knowledge about HIV/AIDS, the stressful nature of HIV/AIDS care and the anxieties evoked by working with patients with a terminal, contagious disease. The absence of effective support and acknowledgement of these difficulties has resulted in the adoption of individual and collective defences in an attempt to deny the painful reality of their situation. The impact of the work, however, now appears to be manifesting in physical distress and there is a real danger that we may lose these dedicated nurses if their difficulties are not acknowledged and addressed.

More than half of the participants requested information, training and support in the area of HIV/AIDS. This is understandable as the interview material has shown that with so many demands on them, staff often feel a sense of professional inadequacy, a common phenomenon in the field of AIDS care (Miller, 2000). If a holistic approach is adopted in training staff, such an approach is also likely to meet other needs and may contribute to changing staff's attitudes towards patients and increase their willingness to care for them. McCann and Sharkey (1998) suggest that education needs to be more inclusive than merely concerned with biomedical issues of infection

control and should ideally focus on attitudes, conditions of work, the level of support available for staff, as well as exploring broader cultural concerns. Miller (2000), however cautions against the 'quick fix' solution of such a limited intervention and suggests that staff support should occur on three levels in the field of HIV/AIDS care. The first level of intervention concerns the conditions under which staff work and aims to address issues such as resources and policy guidelines. The second intervention regards the provision of skills to empower nurses in the area of HIV/AIDS care and could include courses and training about the illness and the care of psychiatric HIV/AIDS patients. The final intervention concerns the provision of emotional support: this should be ongoing and should ideally be provided in the form of regular supervision. Clinical supervision in this context would have the function of reflecting on and exploring nurses experiences with patients; responding to nurses' feelings associated with the patients distress and pain and how this has affected them; and lastly, ensuring that nurses are working within defined ethical standards.

It is essential that the needs of nurses be addressed and that at least some of their suggestions are implemented in order to preserve the integrity of their work and their emotional and physical well-being. This study is, however, limited due to the small number of participants interviewed and the focus of the interviews. Thus, reasons for participants' reluctance to access support has not been thoroughly explored and requires further research. The study has also focused only on the experiences of nursing staff and future research in this area should include the possible impact of HIV/AIDS work on doctors and other staff on the ward.

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Appendix
Interview schedule

Interviewee no. _____ Gender _____

Age _____ Relationship status _____

Residential area _____

Qualifications _____

No. of years in profession since registration _____

Previous nursing experience _____

Length of time on this ward _____

Amount of training received related to HIV/AIDS _____

What has been your experience of working with patients with HIV/AIDS? (i.e. just on this ward, previously?)

How do you feel about working with these patients? Can you give an example of a patient you have worked with?

What are the difficulties you have experienced? Example?

How do your friends/family feel about your work?

Are there any the positive aspects of your work with patients with HIV/AIDS?

How do you think the patients family and friends cope with the diagnosis?

How do you manage/cope with the difficult aspects of your work? What are your sources of support?

How do you think the hospital could support you in this work?

What would help you in your work with patients with HIV/AIDS?

What do you think the government and society should be doing about the HIV/AIDS problem?